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Heads above the Parapet:
Identity construction and enactment in midwifery
leadership

By

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Table of Contents

1. Introduction	2
1.1 Motivation and rationale for the study	2
1.2 Research gap	4
1.3 Contribution to knowledge	6
1.4 Structure of the thesis	7
1.5 Introducing interviewee number 10	9
2. Theories of Identity	14
2.1 Introduction	14
2.2 Role identity theory	15
2.2.1 Origins	15
2.2.2 Principles of role identity theory	17
2.2.3 Major theorists	18
2.2.4 Identity	19
2.2.5 Interaction	20
2.2.6 Reflexivity	21
2.2.7 Multiple roles and identities	22
2.2.8 Commitment	23
2.2.9 Conclusions	24
2.3 Social identity theory	24
2.3.1 Origins	24
2.3.2 Principles of social identity	25
2.3.3 Major theorists	26
2.3.4 The workings of social identity	28
2.3.5 Conclusions	29
2.4 Interplay between role and social identity	30
2.5 Identity Transition	31
2.5.1 Narrative identity theory	32
2.5.2 Role transition	32
2.5.3 Identity work	34
2.5.4 Professional role identity	35
2.6 Chapter conclusions	36
3. Leadership Theory & the NHS Context	38

3.1 Introduction	38
3.2 Earlier leadership theories	38
3.3 Contemporary leadership thinking	40
3.3.1 Rationale for new thinking	40
3.3.2 Distributed leadership	41
3.3.3 The place of followers	43
3.3.4 Transactional and transformational leadership	44
3.3.5 Leadership conclusions	47
3.4 NHS leadership	48
3.4.1 A brief history	48
3.4.2 Transactional and transformational models in the NHS	49
3.5 Clinical leadership	50
3.5.1 Precursors to current thinking	50
3.5.2 Rationale for clinical leadership	51
3.5.3 Individual-level challenges in clinical leadership	53
3.5.4 Group-level challenges in clinical leadership	53
3.5.5 Organisation-level challenges in clinical leadership	56
3.5.6 NHS leadership conclusions	58
3.6 Leadership in midwifery	58
3.6.1 A brief history	59
3.6.2 Current issues in midwifery	60
3.6.3 The case for a midwifery focus	61
3.7 Chapter conclusions	64
4. Methodology	67
4.1 Introduction	67
4.1.1 The study's purpose	67
4.1.2 Chapter organisation	68
4.2 Philosophy	68
4.2.1 Overview	68
4.2.2 Epistemology	70
4.3 Methodology	71
4.3.1 A qualitative approach	71
4.3.2 Case study research	72
4.3.3 A narrative framework	74

4.3.4	Summary	74
4.4	The study sample	75
4.4.1	Overview	75
4.4.2	The cases	76
4.4.3	The interviewees	80
4.4.4	The online sample	81
4.5	Research design	83
4.5.1	Final study design	83
4.5.2	The central case	84
4.5.3	Summary	86
4.6	Research methods	87
4.6.1	Overview	87
4.6.2	Observation	87
4.6.3	Interviews	92
4.6.4	Online interaction	95
4.7	Data analysis	103
4.7.1	Overview	103
4.7.2	Data management	103
4.7.3	Transcription	104
4.7.4	Process of analysis	104
4.8	Ethical considerations	107
4.8.1	Informed consent	107
4.8.2	Confidentiality and anonymity	108
4.8.3	Data protection	108
4.9	Rigour in qualitative research	109
4.9.1	The interpretivist approach	109
4.9.2	Reflexivity	111
4.10	Chapter conclusions	113
5.	The Path to Leadership	115
5.1	Introduction	115
5.2	The path to leadership	115
5.2.1	Decision-making	117
5.2.2	The place of self-reflection	121
5.2.3	Moving along	124

5.3 Wider structures at work	129
5.3.1 Leadership development programmes	129
5.3.2 Coaching	136
5.3.3 Secondments	138
5.4 Significant others	141
5.4.1 Mentors	141
5.4.2 Role models	143
5.5 Identity acquisition and transition	145
5.5.1 A midwife through and through	145
5.6 Chapter conclusions	147
6. Once a Midwife, always a Midwife?	149
6.1 Introduction	149
6.2 Clinician or non-clinician?	149
6.2.1 Practising clinically now?	150
6.2.2 Reduction in clinical time	150
6.2.3 'Being' a leader	153
6.2.4 Benefits and challenges of a non-clinical role	155
6.3 Credibility	157
6.3.1 A clinical background	157
6.3.2 Maintaining credibility	158
6.3.3 Inter-group comparisons	159
6.3.4 Maintenance of professional group membership	160
6.4 Troublesome areas	163
6.4.1 Offices and uniforms	163
6.4.2 Leaving the gang	169
6.4.3 A rock and a hard place	171
6.5 Inter- and intra-professional issues	175
6.5.1 Relationships with nursing	175
6.5.2 Relationships within midwifery	178
6.6 Chapter conclusions	183
7. A View across the Chasm	185
7.1 Introduction	185
7.2 A strong counter-narrative	187
7.2.1 Rationale for management	190

7.2.2	A removal from clinical life	191
7.2.3	A degree of sympathy	192
7.2.4	Credibility	193
7.2.5	A career in management?	195
7.3	Yawning chasm or converging narrative?	196
7.3.1	Leadership versus management	196
7.3.2	Earlier career views	201
7.3.3	Possible futures	203
7.3.4	The HoM challenge	209
7.4	Chapter conclusions	213
8.	Discussion of Findings	215
8.1	Introduction	215
8.2	Problems in clinical leadership among midwives	216
8.2.1	A surfeit of leaders 'ready now'?	217
8.2.2	Disappointment and disillusionment	220
8.2.3	Lack of validation by the professional group	222
8.2.4	Lack of validation by the organisation	228
8.2.5	Conclusions	230
8.3	'I am still a midwife'	230
8.3.1	Commitment and salience	231
8.3.2	Group identification	232
8.3.3	Shared language and meanings?	233
8.3.4	Narrative identity and challenges of role transition	237
8.3.5	Theoretical conclusions	238
8.4	A return to the research questions	241
8.5	Liminality	243
8.5.1	The concept of liminal space	244
8.5.2	Liminality in leadership development	245
8.5.3	Liminality as supportive structure	250
8.5.4	Conclusions	252
8.6	Unexpected findings	254
8.7	Study limitations	255
8.8	Chapter conclusions	258
9.	Conclusion	260

9.1 Introduction	260
9.2 The path to knowledge	260
9.2.1 Endogenous factors in the transition to leadership	261
9.2.2 Exogenous factors in the transition to leadership	261
9.2.3 Endogenous factors in the enactment of leadership	262
9.2.4 Exogenous factors in the enactment of leadership	262
9.2.5 The development needs of midwifery leaders	262
9.3 Contribution to knowledge	263
9.3.1 Contribution to theories of identity	264
9.3.2 Contextual contribution	266
9.3.3 The case of midwives	269
9.3.4 Implications of new knowledge	270
9.4 Practical Implications	271
9.5 Areas for future research	273
 References	 276
 Bibliography	 291
 Appendices	
1. The Cases	295
2. Interviewees' Career Journeys	296
3. Characteristics of the Forums	298
4. First Interview Guide	299
5. Narrative of Observation Day	301
6. Heather's Story – an excerpt	306
7. Data Analysis Example – the online work	311
8. Emergent Themes Example – the interviews	312
9. Abbreviations	313

List of Tables, Figures and Reflections

Table

4.1 Interview schedule	93
4.2 Online identification	99
4.3 Questions asked online	101
4.4 Responses to online questions	102
4.5 Demonstrating trustworthiness	110
5.1 Career timelines of the LMS interviewees	116
5.2 Self-descriptions of the LMS interviewees	122
7.1 From questions to themes	187

Figure

4.1 Epistemology, methodology & methods	69
4.2 Revised epistemology, methodology & methods	75
4.3 The cases	83
4.4 Research design	84
8.1 Liminality in midwifery leadership transitions	247

Reflections

Finding Theory	14
Hot Topics, Pens Out	126
Still a Midwife?	148
Uniform Stories	168
Leaving the Band 6 Gang	169
The Cream of Nursing	174

The Ideal Job	181
Challenges to my Thinking	286
Possible Future	212
A New Idea	243
Final Thoughts	274

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In memory of John Divall: I hope he would have been proud of his bassoon-playing, baby-catching, thesis-writing daughter.

Declarations

This study was funded by a CASE award from the Economic and Social Research Council.

I declare that the content of this thesis is entirely my own work and has not been submitted as part of any degree at another university.

Abstract

Within the NHS, there has been endorsement of a central role for clinical leaders in the organisation, where clinical leadership is defined as leadership *for* clinicians, *by* clinicians. This is a reflection of recent attempts by the NHS to move from a hierarchical, command-and-control, transactional model of leadership, to one based on a transformational, distributed approach. Assumptions have been made that new models can be adopted within the organisation at clinical level, but literature has identified significant challenges in the introduction of a clinical leadership model. Notable is the long-standing divide between clinicians and managers, with clinicians tending to denigrate the role of managers in the organisation. In addition to this, leadership development has often been unstructured and post hoc in the NHS, but recent policy has suggested a new approach, where clinical leaders are offered timely and appropriate development.

The question arises, how do clinicians make a transition to clinical leadership, and what factors influence the construction and enactment of a clinical leader identity?

To address issues of identity construction in clinical leadership, I focus on the case of midwifery, where there has been a struggle to attain a distinctive professional identity within the NHS. The profession has been singled out for attention in recent reports, on the basis of concerns relating to the ageing workforce profile and the devastating impact of poor or ineffective leadership.

I use an in-depth case study approach, incorporating observation of three midwifery-focused leadership development programmes, narrative interviews with nine midwifery leaders, and interaction with an online midwifery forum, in order to gain insight into the challenges facing midwives who make the transition to leadership roles in the NHS.

Using role and social identity perspectives, I explore the complex interaction between individuals, professional group and wider organisational structures in clinical leadership identity construction and enactment. I challenge ideas of shared language and identity within the midwifery profession, demonstrating the destructive nature of conflict within the professional group, and I address the challenges faced by the profession in establishing a distinctive identity at the organisational level. Both of these issues are found to be important in the construction and enactment of a clinical leadership identity.

Chapter One: Introduction

1.1 Motivation and Rationale for the Study

The motivation for this study can be found at personal level and beyond. As a midwife, coming into the profession in my thirties, and from a very different life as a self-employed musician, I was aware from an early stage of a divide between clinicians and managers. I trained in a maternity unit which underwent a significant service re-configuration during my time there, and accusations were frequently levelled at 'the management' in relation to decision-making that clinicians believed did not have their interests at heart.

On qualifying, I moved to a very different unit, in which a medical hierarchy was strongly evident within midwifery – a shock for someone coming from a midwifery-led care philosophy – and the midwifery management team seemed far removed from the frontline of service provision (a model I now understand as command and control, transactional leadership). Eighteen months post-qualification, I moved hospitals once more, this time finding myself in a busy, but well-staffed maternity unit. But the same accusations were being laid about 'the management': midwives suggested they were powerless in important decisions about their own working lives, and claimed managers had no real idea of what it was to be a clinician, as they had left the frontline far behind, now spending their time in offices and pointless meetings.

My own impression was somewhat similar, when we struggled at clinical level with our staffing. I can remember a particular shift, where we were severely compromised due to staff shortages, and my sense of frustration that the senior clinical midwives were attending a meeting in a room adjacent to the ward!

However, I did form a positive opinion of our head of midwifery. In conversations, I found her to be passionate about the profession, and entirely committed to her midwife identity.

In the process of evaluating a significant change to midwives' work patterns within the unit, which the head of midwifery had asked me to lead, I began to realise her plight as middle manager: directed from above, responsible for implementing below.

I came across the idea of structure and agency during a philosophy module, undertaken as part of my Masters in research methods, and through this I gained a framework for my conundrum: midwives identified themselves as autonomous practitioners (a highly significant part of midwives' professional identity), as advocates for women, as empowering agents. But at the same time, victims of the organisational structure, in which 'the management' denied clinical midwives power over their own working lives and made decisions without adequate or appropriate consultation.

And so I came to the PhD as an ERSC case-funded student, and I learned of the bigger picture in NHS leadership. The media have had a field day in recent years, denigrating NHS managers as useless, pointless, pen-pushing bureaucrats (NHS Confederation, 2007; Kings Fund, 2011). Meanwhile, several high profile reports have concluded that poor leadership is at the root of NHS service failures (e.g. Francis, 2013; Commission on Dignity in Care, 2012). But what often seems unclear is what is meant by 'NHS manager'; from my own experiences I would associate the definition with roles such as ward team leader, matron, or head of midwifery, as much as I would with a director or nursing or a trust chief executive, but I'm not sure whether clinicians, the public or the media include clinical leaders in the general criticism of NHS management structures.

The seminal report of 2008, Lord Darzi's Next Stage Review, emphasised the role of clinicians in NHS leadership, and this idea has since been enshrined within the Health and Social Care bill of 2012. Clinical leaders have been conceptualised as essential to ensuring the competent leadership that is associated with better patient care and experience, and in achieving the huge financial savings required by the organisation (e.g. Nicol, 2012; Storey &

Holti, 2013; Phillips & Byrne, 2013; Murphy *et al*, 2009). However, several points remain unclear:

1. Whether clinical leaders are in fact the ideal people to deliver the required changes;
2. How attractive clinical leadership roles are, and will be, to this and the next generation of clinicians;
3. The significance and impact of a professional identity on clinical leadership.

Recent research into clinical leadership has identified several significant challenges in making a transition from clinical to leadership and managerial roles (Osborne, 2011; Nicol, 2012; Kippist & Fitzgerald, 2009; Murphy *et al*, 2009; Dopson & Fitzgerald, 2006). These relate to career decision-making and structures; training and development for clinical leaders; credibility with clinical colleagues; relationships with non-clinical managerial colleagues; and the challenge of developing and maintaining a hybrid clinical-managerial identity (Ham *et al*, 2010; Doolin, 2002).

1.2 The Research Gap

The challenges identified through studies of clinical leadership, among both doctors and nurses, are related largely to the field of identity construction and enactment. Challenges can be identified at individual, professional group, and organisational structure levels, offering clear links with contemporary leadership thinking more generally. In the post-heroic model of leadership, construction and enactment of a leader identity is seen to occur relationally and contextually (Uhl-Bien, 2006; Osborn, 2002), and within wider organisational structures (Fletcher, 2004). Leadership is seen less as hierarchically organised, and more as a fluid and unfixed concept (Gronn, 2008), in which various members of the organisation take on leadership roles at particular times (Yukl, 1999), and

in which leadership is seen as a process of attributed influence, rather than as a single desirable set of skills, knowledge and characteristics (Gronn, 2002; Hartley & Benington, 2011).

However, the NHS approach to leadership has tended to continue with an individualistic focus, and leadership development programmes are based on a competency approach (Cook & Leathard, 2004). Leadership development in the NHS has tended to be de-contextualised, and clinicians and established service leaders have described the difficulty in bringing classroom-based learning back to the clinical frontline (Howieson & Thiagarajah, 2011; Phillips & Byrne, 2013). A significant element within this challenge has been clinicians' views of leaders, where service leaders have been conceptualised in clinical life as managers – and as I described earlier, this view has negative connotations of distance and a lack of empathy or understanding (Kings Fund, 2011; Kings Fund, 2012).

Looking at clinical leadership in this manner, it becomes evident that there is a strong interplay between the clinical leader as individual, as professional group member, and as organisational employee. This makes an individualistic approach insufficient for exploring clinical leadership at theoretical level, and also means that applying only a group-level analysis is similarly lacking in explanatory power. Further, a theoretical perspective on identity construction in clinical leadership has so far been lacking, which makes this thesis timely and necessary, given the NHS' commitment to the development of clinical leaders throughout the organisation.

In summary, the research gap is threefold:

1. Synthesis is necessary in literatures around identity construction generally, with role and social identity theories together proving valuable frameworks for exploration of individual, group and organisational impact on identity construction;

2. Analysis of identity construction and enactment in clinical leadership is currently under-theorised;
3. Identity construction in clinical leadership happens at individual, professional group, and structural levels, with no single area gaining primacy. Thus, theoretical insight should accommodate all three levels of analysis.

1.3 Contribution to Knowledge

In summary, there is a theoretical gap in identity construction, with recent calls for more consideration of the interplay between role and social identity (Beech, 2011; Terry, Hogg & White, 1999; Sluss & Ashforth, 2007; Thoits & Virshup, 1999). This is clear in the question of clinical leadership, where there has been insufficient attention to ideas of identity construction and enactment at a theoretical level. Therefore, the thesis uses clinical leadership to extend ideas of identity construction and enactment at individual, group and organisational levels as a complex interaction, demonstrating the value of exploring both role and social identity when answering questions of leadership identity.

At a contextual level, the thesis offers important signposts to the future of NHS leadership, asking questions about the respective role of individual leaders, professional groups, and organisational structures in the development and enactment of clinical leadership.

The exemplary case explores the issue of clinical leadership in midwifery, a profession that has been highlighted in recent years in relation to the need for strong and effective leadership (DH, 2007), and one with an identified potential shortage of leaders within the next few years (DH, 2010). While midwifery represents the subject of clinical leadership in this thesis, ideas of identity construction and enactment in professional-managerial roles can be extrapolated to wider organisational studies, both within and beyond the NHS.

To summarise, the contribution to knowledge presented in this thesis relates to both theory and context:

1. The extension of ideas of identity transition through the evocation of role and social identity theories, and the interplay between these theoretical perspectives;
2. An exploration of the challenges of clinical leadership in the NHS at a theoretical level;
3. An examination of NHS leadership development and enactment thinking in the context of contemporary theory, centred on a transformational, distributed model of leadership.

1.4 Structure of the Thesis

While I demonstrate throughout the thesis that there was an iterative, non-linear aspect to much of the work undertaken, the document is constructed in a traditional manner for ease of travel. As such, the chapters are laid out as follows:

Chapter Two is a presentation of the broad theoretical framework which has guided the study. I offer descriptions of both role and social identity theories, and explain the rationale for applying both perspectives to the study. I follow this with an overview of the place of narratives in identity construction, focusing on the necessity for identity work in narratives of role identity transition.

Chapter Three introduces the contextual literature within which the study is situated. I move through the broad field of leadership theory to show how contemporary thinking has impacted on leadership in the NHS. This section is followed by a critique of clinical leadership, and finally the midwifery context is introduced, with a defence of the study's focus on this profession.

Chapter Four concerns ontological, epistemological and methodological issues. I describe each in detail, and then move on to consider the methods used to address the research questions. I set the scene in relation to the areas where data were gathered, and give details of the data analysis process.

Chapter Five, 'The Path to Leadership', presents data concerning the career journeys of nine midwifery service leaders, interspersed with observational data and personal reflections. Themes are developed in relation to role identity construction in midwifery leadership, largely from the individuals' perspectives, and demonstrating the interaction between them and the wider organisational structures.

Chapter Six, 'Once a Midwife, Always a Midwife?' concerns 'being' a leader at the group level of analysis. Interviewees' narratives are presented, again supplemented with observational and reflective data, in order to show the strong interplay between individuals, their professional group and organisational structures in the enactment of clinical leadership.

Chapter Seven, 'A View across the Chasm', offers a strong counter-narrative to that presented in the previous data chapters. Themes emerging from my interaction with an online midwifery forum are described, and I show a somewhat surprising parallel between clinicians and clinical leaders.

Chapter Eight is a detailed discussion of the study's findings. I explore the challenges of clinical leadership in midwifery from contextual and theoretical perspectives. I present an alternative approach to identity transition, exploring how a re-thought model might offer a quite different environment for the construction and enactment of clinical leadership in the NHS.

Chapter Nine offers a conclusion to the work. I draw together the study's findings, explaining their contribution to theoretical and contextual literature, and offering suggestions for future research in this field.

1.5 Introducing 'Interviewee Number 10'

'The artist is never bored. She looks at everything and stores it all up. She rejects nothing; she is completely uncritical. When a problem confronts her she goes through all the stuff she has collected, sorts out what seems to be helpful in this situation, and relates it in a new way, making a new solution. She prepares for leaps by taking in EVERYTHING' – Kent, cited in Smith (2008).

'Before familiarity can turn into awareness the familiar must be stripped of its inconspicuousness; we must give up assuming that the object in question needs no explanation. However frequently recurrent, modest, vulgar it may be it will now be labelled as something unusual' – Brecht, cited in Smith (2008).

I find resonance in both of these quotes. The first relates to my overall approach to the study, an approach that has made the research process so enjoyable. During the past four years, I have lived the life of an explorer – I have referred to this in a blog post as my 'pit of think'. At no other time in my life have I had the opportunity to explore so many subjects and spend time immersed in them. As Keats wrote, you do not dive into the lake simply to swim back to the edge; you want to experience the sensation of 'being' in the water, the different perspectives you can gain there, the sensory stimulation, the feeling of being at least partially submerged. This has been my approach to the study, and I don't believe any of the exploration has been wasted.

Some of the areas in which I at least paddled included Wright Mills' sociological imagination (1959); a conference exploring historical perspectives on midwifery; a

workshop on poetry as performance; and an exhibition exploring ideas of photography as situated narrative. Wright Mills helped me to build connections between the private troubles of individual midwifery leaders and the wider issues of NHS leadership and management; a historical perspective on midwifery enabled me to contextualise the contemporary version of the profession within its troubled past; exploring performance poetry offered me the freedom to look at how my authorship of the thesis might retain a sense of my own identity among the many voices I am representing here; and photography gave me ideas about what it was that I was constructing in the act of writing a representation of midwifery leadership.

The other quotation, from Brecht, is significant in its echo of the ethnographer's maxim: making the familiar unfamiliar. When I came to the doctoral studentship, I thought I understood midwifery. In some ways, I did: I spoke the language of the profession, I could reel off the latest 'big picture' issues and policies... But in the process of undertaking the research presented here, I came to realise just how much I did *not* know, working as I did at band 6 – that is, not in a management role. The Strategic Health Authority (SHA), for example, was a completely unknown area for me, and the lives of matrons and Heads of Midwifery (HoMs) were largely hidden. It struck me that I knew many of the micro issues of midwifery in my unit at the level of day-to-day practice, and I knew something of the macro issues of midwifery in terms of current national agendas, but the raft of perspectives in between was something of a mystery.

In the process of observing leadership development programmes and interviewing midwifery leaders for this study, I discovered my identity as insider-outsider. I was welcomed by the programme delegates as an insider; in fact, I knew some of them personally from my days as a clinician, as I had worked in several of the units within the SHAs responsible for the programmes. The delegates included me in discussions, made me

feel welcome during breaks and at meal times, and they encouraged me to believe this study might be useful and relevant to midwifery more widely. Similarly, the programme facilitators treated me as a midwife – it became necessary at times to remind them that I was not actually a participant in the programme!

But within myself, I felt like an outsider. I sat in planning meetings, where the programme was discussed in terms of cost analysis, SWOT analysis, project development – terms that were quite new to me. And during the programme I was an outsider for two reasons: first, the participants were leaders and managers of maternity services provision, whereas I had worked only at floor level, albeit with some exposure to Trust management during the shift evaluation I mentioned earlier. I nodded sagely during discussions about service commissioning, and then went away to find out what I needed to know on the subject. The programme took place during 2010, so there was a huge amount of NHS change happening at the time.

Second, I was acutely aware of my role as researcher: carefully observing and noting significant events and interactions, always considering their relevance to the research questions and overall aims of the study.

This was indeed a process of making the familiar unfamiliar – but also one of making the unfamiliar familiar! As the process of writing up brings to a close a significant part of my life, I understand those two opening statements more fully: the value has been in the opportunity to open my eyes and look more closely into the world of NHS leadership, and to explore my own familiar, yet unfamiliar, world of midwifery. I hope that by examining role and social identity in midwifery leadership development and enactment, this work will go some way to bridging the chasm between service leaders and frontline practitioners.

The writing of this thesis has been my biggest challenge. Not the content, for there is much to say! Rather, the challenge has been in producing a document that adheres to the conventions of academic writing, but in which my own voice can also be heard – but not be allowed to drown out the voices of others. This issue has followed me throughout the PhD process. Very early on, a professor at Nottingham (where I began this explorer life) suggested that, given my midwifery identity, I could write the thesis as an auto-ethnography. Much reading and discussion followed, but ultimately it was an easy decision: this research is not about me; I am not the centre of the study. However, I am clearly a character within the study's narrative, and my midwifery identity has been significant at every stage. While looking into the idea of auto-ethnography (Ellis, Adams & Bochner, 2011; Wall, 2008; Ellis & Bochner, 2000), I came across narrative ethnography (Tedlock, 1991) as a middle ground. Here, the author is visible as a character in the study – not the central player, but a character all the same.

This approach answered my worries in two ways: first, I was keen to produce a representation of more than just the data gathered during the research process. Having lived the life of a clinical midwife, and with many of my friends still working in the profession, I felt there were stories to be told alongside the data. So throughout this thesis, you will find anecdotes and remembered conversations, to illustrate how the data sit within the living, breathing world of midwifery. Second, I wanted to be able to write in a style that, while academically sound, gives a sense of the 'life' of the research experience. To this end, I have written largely in the first person, and have at times included descriptions of the complexities of the research process as it happened.

As a character in this story, I present details of my own identity transition at various points in the thesis – an identity transition in the context of a thesis dealing with ideas of identity

transition in NHS clinical leadership: stories within stories. As my first academic supervisor put it, I have become 'interviewee number 10'.

Chapter Two: Theories of Identity

2.1 Introduction

In this chapter I explore theories of role and social identity, and examine the links between the two in relation to identity construction and enactment. The origins of the theories are described, along with summaries of the main theorists' perspectives; that is, Stryker and Burke for role identity theory, and Tajfel and Turner for social identity theory. Finally, the two theories are explored in terms of their similarities and differences, and I propose an argument for a drawing together of role and social identity in relation to the subject of identity construction and enactment. The chapter serves as a broad theoretical context for the study, and leads into a discussion in the following chapter, of the place of role and social identity in healthcare leadership.

Finding Theory

It's December 2009, and I'm standing in a room at the Business School in Nottingham, having just presented my research in four slides, a requirement of one of the core PhD modules. I'm just happy to have managed to cover the study in so few slides. I've described the study's context, the recent narrowing of focus to exclude nurses and allied health professionals, and the beginnings of a literature review – theories of leadership, talent management, and the use of competency frameworks.

'So,' says one of the examination panel, 'What's your theoretical framework?'

I'm completely stumped. I don't know what's meant by a theoretical framework. Is that not what the leadership theory section is for?

I'm rescued by the ensuing discussion between my first academic supervisor and the examiner: identity theory? Social identity theory? Institutional theory? I promise to go straight away and start looking.

Four years later, I can laugh at the months following that discussion, but at the time it

was head-spinningly, brain-explodingly intense. I remember having conversations with my supervisors during that time, and feeling like somehow, I was missing something. Even at my WBS completion review two years after that first presentation, I was advised that I needed to invert my focus, as I continued to think contextually first, theoretically second.

In the process of writing up the data over the past few months, and after a six-months break in proceedings, I have finally been able to understand how in fact, everything I have been writing relates to the theoretical literature. The sheer usefulness of the theoretical framework, the way it has shaped the research design, the data gathering, the analysis process, and how it has shaped my thinking, has become clear.

But how to present this in relation to the literature review chapters? The problem of a falsified narrative rears its head again: if I put the theoretical review first, it suggests I've never had a problem with theoretical-level thinking, and that is far from the truth. But if I put the context first, am I going to face suggestions of shoe-horning a theoretical framework in, which makes it sound like I don't really believe in it?

Hopefully this reflective account goes some way to showing the complexity and non-linearity of the process of designing the study, and my gradual path to understanding what one of my supervisors said to me when I was trying to decipher this new world of theoretical thinking:

'There is nothing so practical as a good theory' – Lewin (1952:169).

2.2 Role identity theory

2.2.1 Origins

The roots of role identity theory can be traced to the symbolic interactionist perspective, and the writings of George Herbert Mead. Stryker & Burke (2000) describe a highly simplified version of Mead's formula as "society shapes self, shapes social behaviour". Identity theory, first presented in 1966 (Stryker & Burke, 2000), began by trying to specify and make researchable the concepts of 'society' and 'self', and to organise these concepts into explanations of human behaviour.

The symbolic interactionist perspective stresses the mutual interdependence of the self and society, where one cannot exist without the other. While society provides a shared language and meanings, enabling the individual to take the role of 'other' and so acquire a variety of self-conceptions, at the same time individuals tend to recreate the social order in enacting social identities (Thoits & Virshup, 1997; Machin, Machin & Pearson, 2011).

The traditional symbolic interactionist approach sees society as always in the process of being created through the interpretations and definitions of actors involved in situations, but Stryker (1968:65), the original proponent of identity theory, instead proposed society as stable and durable, writing that this is demonstrated in the "patterned regularities" that characterise most human behaviour. According to this argument, the probability of entering into the discrete social networks in which people live their lives is influenced by the larger social structures in which these networks are embedded. Thus, social structures outside given networks act as boundaries, which affect the probability that people will enter such networks (Stryker & Burke, 2000). According to Stryker, this involves treating the self as a complex, differentiated unit, in contrast with the model of the self as undifferentiated and unorganised described in the traditional symbolic interactionist approach. Stryker suggests four premises of a symbolic interactionist model in this structured approach:

- Human behaviour is premised on named and classified worlds, where names and class terms carry meaning consisting of shared behavioural expectations emerging from social interaction. This interaction teaches individuals naming, classifying and behaviour;
- Among class terms are symbols, which designate the stable components of social structure, also called 'positions'. These positions carry shared behavioural expectations, labelled 'roles';

- Actors in society name one another, as well as themselves, creating expectations with respect to their own and others' behaviour;
- Behaviour is a product of the role-making process. It is initiated by expectations, but then developed through a subtle, probing interchange among actors in given situations, an interchange that continually reshapes both the form and content of the interaction between actors (Stryker, 1968).

2.2.2 Principles of role identity theory

Role identity theory is micro-sociological (Desrochers *et al*, 2002), linking self-attitudes, or identities, to role relationships and the role-related behaviours of individuals. The theory began with questions about the origins of differential salience of identities in people's self-structures, and why salience might change over time (Stryker, 1968). These questions led to the development of a theory concerning ways in which people are tied into the social structure, and the consequences of such ties for their identities. The theory then asserted a link between identity salience and behaviours tied to roles underlying identities, with theorists arguing that expectations attached to roles become internalised by individuals and then acted out (Stryker & Burke, 2000).

The main assertion in identity theory is that role choices are a function of identities (which are conceptualised as internalised role expectations), and that identities within the self are organised into a hierarchy of salience, reflecting the importance of hierarchy as an organising principle in society (Stryker & Burke, 2000). Theorists argue that the self consists of a collection of identities, each of which is based on occupying a particular role (Desrochers *et al*, 2002). In this way, social structure is made up of interconnecting positions and associated roles, each linked through activities, resources, and meanings that are controlled mutually and sequentially (Stryker & Burke, 2000). Identity theory stresses the importance of the interplay between agency and social structure, in that people are

described as always embedded in a social structure that is at the same time being created by those individuals. This social, or societal, context is the central issue in distinguishing sociological approaches to the study of the self (Stets & Burke, 2003).

2.2.3 Major theorists: Stryker and Burke

Stryker's emphasis is on social structure, examining how this affects the structure of the self, and how the structure of the self influences social behaviour (Desrochers *et al*, 2002). He arrives at behaviour by moving from social structures to commitments to relationships, through the consequent salience of the identity to behaviour (Stryker & Burke, 2000). He defines identity salience as "the probability, for a given person, of a given identity being invoked in a variety of situations", with a further definition given as "the differential probability among persons of a given identity being invoked in a given situation" (Stryker, 1968). Either way, a rank order of probabilities defines the hierarchy of salience.

The hierarchy described by Stryker becomes important in the prediction of behaviour in the event of a structural overlap, which is when analytically distinct sets of relationships become mutually contingent at some time, and so invoke concurrently different identities (Stryker, 1968). If different identities call for incompatible behaviour, the hierarchy of salience becomes a potentially important predictor of behaviour.

While Stryker's emphasis is on social structure and its interplay with the conception of the self, Burke emphasises socio-cognitive systems, identity maintenance processes, and the content of identity (Desrochers *et al*, 2002). Burke arrives at behaviour by moving from internalised identity standards and perception of self-relevant meaning, through a comparison of the two that either verifies the identities or indicates a discrepancy, to behaviour that repairs the discrepancy either by altering the situations or by creating new situations (Stryker & Burke, 2000). By concentrating on the internal dynamics of self-

processes as they affect social behaviour, Burke's conceptualisation of identity thus neglects ways in which external social structures impinge on internal processes (Stryker & Burke, 2000).

Burke also theorises that role identities contain a set of multiple meanings, where different individuals may attach different meanings to the same role identity. The meanings of identities have implications for how individuals behave, and an individual's behaviour confirms an identity when they share meanings (Stets & Burke, 2003). Burke's more recent work has expanded on the notion of a correspondence of meaning between identity and behaviour (Stets & Burke, 2003), devising a cybernetic model where the internal dynamics of identity are clearly seen. According to this model, behaviour is seen as the result of a relationship between a situation and internal self-meanings, and role behaviours are seen as a means by which individuals strive to keep their perceptions of self-relevant meanings in a situation in line with the meanings held in the identity standard – this is the striving for self-verification, where self-verification can only be accomplished by co-operative and mutually agreed arrangement of role performances.

2.2.4 Identity

According to Burke & Reitzes (1981) an identity is "like a compass helping us steer a course of interaction in a sea of social meaning". Within identity theory, Desrochers *et al* (2002) define identities as an answer to the question, 'Who am I?' The answer is linked to the roles we occupy, in identity theory referred to as 'role identities', or simply 'identities'. Stets & Burke (2003) define identities as "the overall self organised into multiple parts, each of which is tied to aspects of social structure". In this definition, identities are the meanings one attaches to being a group member, role-holder, or individual, with the core of an identity being the categorisation of the self as a role occupant, incorporating into the self the meanings and expectations associated with the role and its performance. Of equal

importance, according to Stets & Burke (2003), is the idea that any identity is always related to a corresponding counter-identity.

In the terms used within identity theory, Burke & Reitzes (1981) describe four distinctive features of identities:

- Identities are social products; they are formed, maintained and confirmed through processes of naming and locating oneself in social categories, through interacting with others in terms of these categories, and through engaging in self-presentation and alter-casting to negotiate and confirm meanings and behavioural implications of the social categories;
- Identities are self-meanings acquired in particular situations, and are based on the similarities and differences of a role in relation to its counter-roles;
- Identities are symbolic, calling up the same responses in one person as in another;
- Identities are reflexive. People use them as reference points to assess the implications of their own and others' behaviour.

2.2.5 Interaction

Interaction is mainly between individuals occupying positions in groups or organisations in society, so interaction is between aspects of people – rather than whole people – based on their roles, and group or organisational membership (Stets & Burke, 2003). Others respond to individuals as performers within a particular role (Burke & Reitzes, 1981), and self-meanings are learned from others' responses to one's actions in such roles (Machin, Machin & Pearson, 2011). Others judge one's actions as appropriate or inappropriate for the identity one holds, and appropriateness can only be gauged in terms of the meaning or the behaviour relative to the meanings of the identity and counter-identity (Burke &

Reitzes, 1981). Once again, this emphasises the cyclical and reflexive nature of human interactions.

The nature of interaction can be examined through a lens of social structure or of human agency (Stets & Burke, 2003). Social structure focuses on the external, with actors taking or playing a role. The social structure is quite fixed, and people play the roles they are given, with only minor variations evident between people taking the same identities. In this perspective, the social structure persists and develops according to its own principles – actors may come and go, but positions mostly remain. Through a human agency lens, however, it is individuals who make and create roles by making behavioural choices and decisions, engaging in negotiation and compromise as well as conflict in their interactions with others. Stets & Burke (2003) believe it is important to address both social structure and human agency when examining the nature of interactions, writing that it is important to understand how social structure is the accomplishment of actors, but also how actors always perform within the social structure they create. This view relates strongly back to the principles of symbolic interactionism, with its interplay between the self and society, neither of which can be separated from the other.

2.2.6 Reflexivity

Reflexivity can be seen as key to human interaction, because the ability of humans to reflect back on themselves, taking themselves as objects, means they can regard and evaluate themselves, take account of themselves to bring about future states, and be self-aware and achieve consciousness in terms of their existence (Stets & Burke, 2003). By taking the role of 'other', and seeing themselves from others' perspectives, individuals' responses become like others' responses, and the meaning of the self becomes a shared meaning. According to Burke & Reitzes (1981), reflexivity provides individuals with a

standpoint or frame of reference in which to interpret a social situation, as well as his or her own actions and potential actions.

From this perspective, the interplay between self and society becomes clear once again. Reflexivity is at the core of selfhood – the self emerges in and is reflective of society (Stets & Burke, 2003), therefore any sociological approach to understanding the self and its parts means it is also necessary to understand the society in which the self is acting, and keep in mind that the self always acts in a social context in which other selves also exist. There is a paradox emerging from this reflexivity, however, in that as the self emerges as a distinct object, there is at the same time a merging of perspectives of the self and others, and a becoming as one with the others with whom one interacts. Again, the self can be seen as both individual and social in character (Stets & Burke, 2003).

2.2.7 Multiple roles and identities

Early work in identity theory attempted to apply the theory to work and family, in support of a role accumulation hypothesis. This hypothesis suggests that because identities provide people with purpose and behavioural guidance, so self-esteem and other aspects of psychological well-being are achieved by having more identities and being more strongly committed to them all (Desrochers *et al*, 2002). Thoits (1983, 1986) suggests that multiple role identities may be more beneficial than harmful, while Stets & Burke (2003) assert that, according to self-complexity theory, more complex selves are better buffered from situational stress. Smith-Lovin (2001, cited in Leary & Tangney, 2003:136) writes that the more complex self is a result of a larger network of identities, especially where others in the network are less similar to each other.

However, Thoits (1992) believes the positive effects of multiple role identities may be contingent on the kind of role being accumulated. Research showed that obligatory roles,

such as parent, spouse, or worker, were only beneficial to mental health when chronic strains in each role were low. Meanwhile, voluntary roles, such as friend or neighbour, were shown to significantly reduce psychological distress – a finding that Thoits ascribes to the fact that such roles are less physically and psychologically demanding, and also due to the fact that they are easier to leave, should the costs of the identity exceed the rewards.

Stryker & Burke (2000) believe the larger a network is, the more likely it is that it will contain individuals whose membership in other networks or groups may create identities that reinforce or impede various forms of participation, particularly as a multiple identities conception requires internalisation of role-related expectations, and the ordering of the various identities into a hierarchy of salience. Desrochers *et al* (2002) make a similar argument, asserting that a conflict of identities can mean commitment to multiple identities becomes stressful. This argument has been highlighted in literature around working women's conflicts and dilemmas concerning the interplay between work and family demands, with Stryker & Burke (2000) finding that diverse roles may result in conflicting, or competing, expectations for individuals' behaviour. Simon (1995) found that the majority of men in her study saw work and family roles as interdependent and overlapping, and did not report negative outcomes through combining the roles. Women in the study, however, perceived the roles as independent, in the sense that they were unable to perform work and family roles at the same time, and reported negative psychological consequences.

2.2.8 Commitment

Commitment in identity theory refers to relationships to others, formed as a function of action on choices – a changing pattern of choice requires a changing pattern of relationships to others (Stryker, 1968). According to Stryker (1968) and McCall and Simmons (1966), commitment is one way in which individuals infuse the self and subjective

meanings into a role, with commitment being related to identity salience, self-esteem and role evaluations (Burke & Reitzes, 1991).

In Stryker's model, a greater commitment to an identity results in that identity appearing higher in the salience hierarchy; further, the larger the number of people included in a network of commitment that is premised on an identity (where that identity is high on the individual's own salience hierarchy), then the higher that identity will appear in the salience hierarchy. Burke and Reitzes (1991), applying the cybernetic model principles, define commitment as "the sum of the forces, pressures, or drives that influence people to maintain congruity between their identity setting and the input of reflected appraisals from the social setting", where greater commitment suggests greater correspondence between reflected appraisals and the identity setting. Following their empirical work on student identity and commitment (1991), Burke and Reitzes concluded that individuals undertake activities that support and sustain particular identities in relation to the level of their commitment to those identities.

2.2.9 Conclusions

Role identity theory is concerned largely with the individual, and his or her relationship with the wider social structure. While the theory undoubtedly offers great insight into elements of identity, the emphasis is clearly on the individual's perceptions and the interplay with wider social structures from an individualistic perspective. However, individuals exist within a large number of groups, and the review now turns to an exploration of social identity, examining group membership as a further unit of analysis in identity construction and enactment.

2.3 Social Identity Theory

2.3.1 Origins

Social identity derives from a fundamental tension between individuals' need for validation and similarity to others (de-individuation), and their need for uniqueness and distinctiveness (individuation). Social identity represents a compromise (Brewer, 1991), where the need for de-individuation is met through in-group membership, and the need for distinctiveness is met through inter-group comparisons. Thus, group identities allow for sameness and difference at the same time. The basic tenet of social identity theory is that the social category into which individuals fall, and to which they feel they belong, provides a definition of the self in terms of the defining characteristics of the category (Tajfel & Turner, 1979:40; Hogg, Terry & White, 1995). Individuals have a repertoire of discrete category memberships that vary in relative overall importance within that person's self-concept, and each membership represents a social identity that describes and prescribes one's attitudes as a member of the group (Hogg, Terry & White, 1995). Thus, the essence of social identity theory is a concern with aspects of identity that derive from group memberships (Skevington & Baker, 1989:1), where social identity may be described as the processes and assumptions that explain the relationship between socio-cultural forces and individual social behaviour (Hogg & Abrams, 1988:13).

Social identity theory has been described as "the spearhead of an attack on individualism in social psychology" (Hogg & Abrams, 1988:13), developed from a desire for a non-reductionist social psychology that would be able to express the dynamic relationship between the individual and society without individualising it; thus, to explore the social dimension of human behaviour.

2.3.2 Principles of Social Identity Theory

According to Tajfel and Turner (1979:40), there are several distinctive principles of social identity:

- Individuals strive to achieve and maintain a positive social identity;
- A positive social identity is based largely on favourable comparisons between in-group and relevant out-groups; the in-group must be perceived as positively differentiated and distinct from the relevant out-groups;
- When a social identity is unsatisfactory, individuals will strive to leave the existing group to join a more positively distinct group, and/or strive to make their own group more positively distinct.

Social identity provides a link between the psychology of the individual, and the structure and processes of social groups in which the self is embedded (Brewer, 2001). The concept of social identity is invoked when theorists attempt to 'build a bridge' between individual and group levels of analysis (Brewer, 2001). Ashforth & Mael (1989) expand on this theme, writing that one's social identity represents the part of the self-concept that encompasses salient group classifications, while the other part is one's personal identity, which encompasses idiosyncratic characteristics. As Brewer (1991) asserts, simply belonging to a group does not result in automatic adoption of classifications as social identities, because individuals are selective. Brewer suggests that specific social identities may be activated at some times and not others, while Ashforth & Mael (1989) stress that social identification only occurs when there exists a perception of oneness with or belongingness to some human aggregate. Hogg & Abrams (1988:7) believe that social identity and group belongingness are inextricably linked, in that an individual's identity is largely made up of self-description in terms of the defining characteristics of the various groups to which he or she belongs. They describe identification with a social group as a psychological state, "phenomenologically real, with important self-evaluative consequences", which is different from simply being designated as falling into one or another social category.

2.3.3 The Main Theorists: Tajfel and Turner

Tajfel argued for a social psychology that emphasised the wider social context within which individuals act (Thoits & Virshup, 1997), his work initially being a development of Festinger's (1954) theory, that identity formation rests on a process of social comparison for people to evaluate their opinions and abilities (Skevington & Baker, 1989:2). Tajfel described the way in which work on the social psychology of intergroup relations had previously focused on patterns of individual prejudice and discrimination (Tajfel & Turner, 1979:33), and instead developed social identity theory to explain how people conceptualise themselves in intergroup contexts, and how a system of social categorisation creates and defines an individual's place in society (Hogg, 2001). Thus, social identity is described as focusing on "the complexities of interweaving individual and interpersonal behaviour with the contextual social processes of intergroup conflict and its psychological effects" (Tajfel & Turner, 1979:33).

Where Tajfel's main concern was intergroup relations, particularly group conflict and competition, Turner's focus is on cognitive processes that create a collective sense of self and make possible group-level phenomena, such as social stereotyping, group cohesiveness, shared norms, and collective action (Turner *et al*, 1987:50). However, Tajfel's and Turner's theories are seen as complementary, with Tajfel's emphasis on *inter*-group relations as a product of social identity, alongside Turner's emphasis on *intra*-group behaviour (Thoits & Virshup, 1997).

Tajfel's and Turner's explanations of motivational bases for group behaviour differ. According to Tajfel, the explanatory mechanisms for collective behaviour are the needs for positive group distinctiveness and individual self-esteem, whereas for Turner, the mechanism through which people become a psychological group is one of depersonalisation, as an individual's unique characteristics fade from awareness and the individual defines him or herself in terms of stereotypical group characteristics (Thoits &

Virshup, 1997). This leads to group behaviour, which consists of cohesiveness, cooperation and conformity.

2.3.4 The Workings of Social Identity

Tajfel & Turner (1979:40) define the group as a collection of individuals with several elements in common:

- They perceive themselves to be members of the same social category;
- They share some emotional involvement in this common definition;
- They achieve some degree of social consensus about the evaluation of their group and their membership within it.

Group memberships act as a buffer to the many threats to individuals' sense of self-worth, and the key to the survival of a group is the maintenance of clear boundaries that differentiate them from other groups (Brewer, 1991). Elements of the group phenomenon include classification, social comparison, and categorisation.

Classification in social identity, where individuals classify themselves and others into social categories, serves two purposes; first, by segmenting and ordering the social environment, classification represents a systematic means of defining others; second, classification enables individuals to define themselves within the social environment (Ashforth & Mael, 1989). Thus, the definition of the self and others is relational and comparative.

Social comparison relates to achieving confidence in the trustworthiness and usefulness of our beliefs (Hogg & Abrams, 1988:22), and results in an accentuation effect, where perceived inter-group differences and intra-group similarities are formed (Stets & Burke, 2000). The accentuation effect is more pronounced when classification is important, salient, or of more relevance to an individual (Hogg & Abrams, 1988:20).

The third element of the group phenomenon is categorisation, which acts to simplify perception. Categorisation serves to give structure to “the potentially infinite variability of stimuli” (Hogg & Abrams, 1988:19), offering a more manageable number of distinct categories, and is again linked to the accentuation effect. Social categorisation results in conflict between in-group (same category as self) and out-group (different category from self), and is based entirely on reference to self. This self-categorisation has two effects; first, individuals perceive themselves as identical to other members of a category and situate themselves within that category; second, category-congruent behaviour is generated based on dimensions perceived as stereotypical of the category. Thus, self-categorisation is the process which transforms individuals into groups (Hogg & Abrams, 1988:21), or to put it another way, from ‘me’ to ‘we’ (Thoits & Virshup, 1997).

An omnipresent feature of intergroup relations is in-group bias, with the mere perception of being two distinct groups enough to trigger intergroup discrimination that favours the in-group (Tajfel & Turner, 1979:38; Schopflin, 2001). This is based on the basic human need for positive self-esteem, which underpins the constant urge to attain a positive social identity (Hogg, 2001); the implication being that self-esteem motivates social identification and group behaviour. The increased self-worth that accompanies a group-based identity may come from the very act of identifying with the group, from an individual’s perspective, but this self-worth may also be linked to the group’s acceptance of the individual as a member of the group. This leads to the suggestion that individuals may act specifically so as to promote acceptance by the group (Stets & Burke, 2000).

2.3.5 Conclusions

While the principles of role identity theory are related to role choices and accumulations from an individualistic perspective, albeit taking into consideration the wider social

structure, social identity theory offers an opportunity to examine identity construction and enactment from a group perspective.

The final part of this chapter explores the links between theories of role and social identity, and I conclude that in fact, both are useful in examining identity construction and enactment, and I offer a justification for a dual theoretical framework in this study of clinical leadership.

2.4 An Interplay between Role and Social Identity

Theories of role and social identity share several ideas: both deal with the dynamic mediation of a socially constructed self between social structure and individual behaviour; both address the social nature of the self as constituted by society; both reject perspectives that treat the self as independent of or prior to society; and both regard the self as differentiated into multiple identities that reside in circumscribed practices (Hogg, Terry & White, 1995). Further, both perspectives acknowledge the fact that role and social identities will vary in relative importance to a person's self-concept (Terry, Hogg & White, 1999).

However, important differences can also be identified: first, the two approaches share different roots – micro-sociological for role identity theory, psychological for social identity theory (Hogg, Terry & White, 1995); second, they differ in their explanatory aims, with role identity theory setting out to explain an individual's role-related behaviours, while social identity theory aims to explain group processes and intergroup relations (Hogg, Terry & White, 1995); third, the individual-level 'me' in role identity is derived from taking the role of other and from responding to others' expectations and reflected appraisals, whereas the collective level 'we' in social identity is derived from the cognitive processes of group social comparison, group categorisation, and group evaluation (Thoits & Virshup, 1997); and last,

role identity theory helps to explain the perpetuation of an existing social order, and is therefore more structural-functional in its orientations, while social identity theory, with its focus on intergroup competition and social change as the consequences of identity-related behaviour, thus comes from a conflict orientation (Thoits & Virshup, 1997).

There have been suggestions of the importance of taking into account both role and social identity constructs in attitude and behaviour relations (Sluss & Ashforth, 2007; Terry, Hogg & White, 1999). The resolution of difficulties within role and social identity theories might lie in a recognition that social roles and socio-demographic categories can be the basis of individual or collective identities:

“If simultaneous awareness (of the ‘me’ state and the ‘we’ state) can occur, then the needs for positive individual distinctiveness may be satisfied at the same time as the needs for positive group distinctiveness” (Thoits & Virshup, 1999).

Similarly, Brewer (2001) suggests that group identification is based on an awareness of shared identities, which presupposes that group members have the group membership as part of their individual social identities, and concludes that neither ‘we’ nor ‘me’ as a definition of identity can be considered superior or prior to the other. Ultimately, collective action and group life is made possible by a dynamic relationship between both elements of identity (Gecas & Burke, 1995:45; Smith, 2011).

2.5 Identity Transition

In this final part of the chapter, I turn to the theme of identity transition. Given the study’s focus on the construction and enactment of a midwifery leader identity, and this chapter’s pre-occupation with the significance of attending to both individual and group levels of identity theory, it seems timely to look at how identity transitions might occur from this perspective.

2.5.1 Narrative Identity Theory

As I described in the introductory chapter, I employed a narrative perspective in undertaking this study. With this in mind, and alongside the aforementioned exploration of identity processes at the individual and group levels of analysis, I turn now to discuss the place of narratives in role identity constructions and transitions.

A number of authors (e.g. Brown, 2006; Somers, 1994) have suggested the relevance of employing a narrative approach to theories of identity. In this paradigm, identity is constructed and enacted through the use of narratives at individual, cultural and societal levels (Watson, 2009). However, while individuals construct identities through the building and development of narratives, this process necessarily takes place within the discourses surrounding them. As Gendron & Spira (2010) suggest, these surrounding discourses specify more or less specifically what constitutes ‘truth’, and are temporally and spatially defined. Similarly, Watson (2009) writes that individuals both use *and* create narratives, but always within a framework of history, social structure, and culture.

Humphreys & Brown (2002) describe organisations as ‘polyphonic dialogues’, where a multiplicity of individual and collective identity narratives are constructed and enacted. Similarly, Brown (2006) describes organisational identities as discursive constructions, perhaps unstable and at times contradictory, but always shaped by a limited repertoire of available or sanctioned stories.

2.5.2 Role Transition

A central consideration for this study is the theme of role transition. Midwives moving from clinical to leadership or management roles necessarily undergo some degree of identity transition. This is because new roles require ‘new skills, behaviours, attitudes and

patterns of interpersonal interactions', and as such 'they may produce fundamental changes in an individual's self-definitions' (Ibarra & Barbulescu, 2010).

As with theories of narrative identity, transition occurs in the context of both internal and external influences; individuals make decisions about discarding and taking up role identities, but always within their particular cultural and historical context (Ashforth, 2000).

In relation to work role transitions, Ashforth (2000:13) writes that the greater an individual's involvement and identification with work, the more transition processes are likely to be 'consequential and potentially taxing', and significant in any role transition is the place of external influences. Ashforth (2000:15) believes a role identity is unlikely to take root within an individual without affirmation by a valued role set, while Ibarra (2007) describes a necessary 'stamp of approval' from an individual's social entourage and organisational gatekeepers if a transition to a new role identity is to be successful. Currie, Finn & Martin (2010) describe the relevance of collective identity constructions in relation to more individual constructions, especially within the context of new roles within the health and social care services.

Role identity transition has been theorised in the context of narratives at the individual, professional group and wider organisational levels of analysis. For example, Ibarra & Barbulescu (2010) believe that transitions depend upon an individual's narrative of change being told within familiar, culturally accepted plots. This makes cultural acceptance more likely at the group level; while for individuals undergoing transition, narratives that can be justified as 'representative of enduring identities' are more likely to become internalised and therefore successfully enacted. Ibarra (2007) believes narratives play a significant role in fostering identity integration after a period of fragmentation or conflict seen during the process of disengaging from one role and engaging with another, while Ashforth (2000:8)

describes individuals needing to articulate 'a narrative thread that connects possibly disparate experiences into a coherent story about themselves'.

2.5.3 Identity Work

Identity work refers to an individual's need to negotiate and optimise boundaries between personal and social identities (Kreiner *et al*, 2006). Successful identity work results in an increased coherence between self-definition and work situations in an organisational setting (Sveningsson & Alvesson, 2003).

A number of authors have described strategies used by individuals to construct and enact identities in this way. For example, Snow & Anderson (1987) developed typologies of identity talk among homeless street people. They found strategies included 'distancing' when individuals had to enact role that were inconsistent with actual or desired self-conceptions; and 'embracement', used to confirm acceptance of or attachment to a particular social identity. Kreiner *et al* (2006) explored how episcopal priests attained optimal balance in their self and social identities, so that they were neither too distinctive and independent of the group, nor too inclusive and dependent on the group. They found individuals using tactics of both integration and differentiation at particular times of their lives.

Once again, the interdependence between individuals and their environment is a dominant theme, exemplified in studies exploring identity work in an organisational setting. For example, Sveningsson & Alvesson (2003) used the case of a single manager to explore the construction of and struggles with various identities held by their 'heroine', and described identity work being necessary due to the precarious nature of identity constructions in this setting. Here, successful identity work was seen to increase identity coherence and possibly to act as a buffer between the individual and 'a threateningly diverse and

ambiguous external world'. Similarly, Watson (2008) employed themes from Wright Mills' conceptualisation of the sociological imagination to explore an individual manager's identity work, showing how such work bridged the individual's self-identities and his socially available discourses.

2.5.4 Professional Role Identity

Of contextual interest to this study in particular, is the place of a professional role identity. Within midwifery, this is an area that has rarely been explored; however, literature concerning physicians' professional identity is plentiful.

Much has been written on the subject of the blurring of boundaries in medical professional roles (e.g. Doolin, 2002; Chreim *et al*, 2007; Pratt *et al*, 2006; Spyridonidis *et al*, 2014), largely due to the rise of hybrid, or boundary-spanning roles among doctors. Every individual must negotiate between a number of discourses in their construction of self (Doolin, 2002), and within healthcare professional roles this is particularly evident, due to the different discourses at work. Chreim *et al* (2007) describe how the construction and reconstruction of the professional role identity of doctors is both enabled and constrained by the institutional environment. Within this environment, there has been significant attention to the 'rise' of leadership, which will be discussed further in the following chapter, in relation to current NHS policy. For now, the significant aspect of such role transitions is what has been described as 'image displays' (Ibarra, 1999), which are considered central to professional roles, and which signal how individuals view themselves and hope to be viewed by others. Ibarra goes on to describe the necessity of both internal and external assessments in professionals' identity work, offering explanations of both elements:

- Internal assessments involve comparing the individual's public persona with their representations of who they 'really' are or wish to be. This is related to the idea that congruence is important from a role enactment perspective: self-representations that are justifiable as representative of the self are more likely to be internalised;
- External assessments involve the observations and reactions of valued role set members who offer the individual feedback. This is important because acting on positive feedback leads to gradual changes in identity, because individuals tend to replicate behaviours that win them approval.

Spyridonidis *et al* (2014) believe such identity work is necessary in order to maintain doctors' salient identity – that of clinician – in the face of the 'wearing many hats', which is a daily requirement for professional hybrids.

2.6 Chapter Conclusions

In this chapter I have outlined and explained the study's theoretical framework. I have explored broad theories of role and social identity, and have demonstrated a strong interaction between both in the construction and enactment of identity. More specifically, I have provided an overview of the importance of identity work in role identity transition, with the significance of individual and group narratives described in this context.

The over-arching theme of the theoretical framework has been the importance of attending to the interdependence of individual, professional group, and organisational context in any examination of identity construction and enactment. Neither an individualistic nor a group perspective alone can fully explain the complexities of identity construction, and I have answered calls for consideration of both individual and group

levels of analysis by adopting a dual perspective to the analysis of the construction and enactment of a clinical leader identity.

The next chapter adds further detail to the rationale for this dual theoretical approach, as I explore broad theories of leadership, and then the context of leadership in the NHS.

Chapter Three: Leadership Theory and the NHS Context

3.1 Introduction

While the previous chapter explored the study's broad theoretical framework, I now move towards the study's context. I begin by examining the development of leadership theory, which has entered a 'post-heroic' era. I explore what this means for leadership in organisations generally, and explain some of the challenges raised. I then move on to NHS leadership, describing its past in relation to earlier leadership thinking, and demonstrating how contemporary leadership theory is feeding into NHS leadership policy. I address the context of clinical leadership, examining what previous studies have to say on the subject, and exploring how all the strands of leadership thinking come together to provide a rationale for this thesis.

Finally, I introduce the midwifery context, and explain the relevance of exploring leadership within this particular profession. I end with a re-iteration of the research questions in the context of the theoretical and practice-based literature addressed in these two chapters.

3.2 Earlier Leadership Theories

The focus in past theories of leadership has typically been on individuals (Deckard, 2010:209), with these individual leaders conceptualised as active players in the process of leadership, and followers portrayed as passive and reactive (Winkler, 2010:5). In this conceptualisation of leadership, there has been a clear definition of who are the leaders and who the followers, and an associated power relationship has been seen to exist in the context of a formal hierarchy (Winkler, 2010:5).

The trait theory of leadership, which emerged from 'great man' thinking (Bolden et al, 2003:6), has been seen to have limited application; that is, traits have not necessarily been

associated with effective leadership in practice (Boseman, 2008). However, Northouse (2007:24-5) believes there may yet be some advantages in looking at leadership from a trait perspective. He suggests benefits including a more intricate understanding of how leaders' personalities might be related to the leadership process, and the benchmarking potential of using personality and assessment procedures in order to gain information about leaders' strengths and weaknesses and assess ways to improve their leadership effectiveness.

Behavioural theories of leadership (e.g. McGregor, 1960; Blake & Mouton, 1964) have been criticised for a lack of attention to effective leadership in different situations (Bolden et al, 2003:8). Just as the trait approach failed to discover a universal set of characteristics, so the behavioural approach failed to identify a universal set of leadership behaviours. On the other hand, Northouse (2007:79) believes there are benefits to such an approach, as it allows leaders to assess their actions and determine how they might change to improve their leadership style.

The contingency or situational school of thought (e.g. Fiedler, 1967; Hershey-Blanchard, 1969) developed the idea of an interaction between a leader's traits and behaviours, and the situation in which the leader exists; thus, the effects of one variable on leadership are contingent on other variables (Horner, 1997). Such thinking allowed the possibility that leadership might be considered different in every situation, and subsequently the emergence of a more realistic view of leadership which allows for "the complexity and situational specificity of overall effectiveness" (Horner, 1997). However, criticism of contingency thinking has centred around a continued individualistic emphasis (Northouse, 2007:111). Despite a consideration for the characteristics of followers and evaluation of relevant situational concerns, the leader remains at the centre of the approach (Horner, 1997), with leaders appointed to an appropriate situation given their individual style of

leadership, or leaders being taught to exhibit different behaviours, or a situation being altered to best match the leader.

3.3 Contemporary Leadership Thinking

In recent years, there has been considerable re-thinking within leadership theory, specifically a move away from a focus on individual leaders, towards a more holistic approach (Avolio *et al*, 2009; Yukl, 1999; Winkler, 2010:5-7). Leadership is now considered less a static set of skills, and more a dynamic process of influence (Hartley & Benington, 2011; Turnbull James, 2011). In this re-conceptualisation, the relational and contextual elements of leadership have been foregrounded (Uhl-Bien, 2006; Osborn, Hunt & Jauch, 2002), with a greater emphasis on the interdependence between workers (Gronn, 2002), and thus consideration of the potential for leadership at every level of an organisation (Roebuck, 2011) and recognition of a place for different types of leadership, for example formal and informal systems (Hartley & Benington, 2011).

The following section of the review considers the rationale for shifts in leadership thinking, and explores the benefits and challenges of contemporary approaches.

3.3.1 Rationale for New Thinking

Reasons for a move away from traditional leadership thinking have been proposed at organisational and theoretical levels of analysis. At the organisational level, Fitzsimmons *et al* (2011) offer a threefold explanation:

- Increased complexity and ambiguity in the workplace has resulted in a shift in the division of labour;
- Senior leaders might no longer alone have sufficient or relevant information to make effective changes;

- Knowledge workers have differing expectations and specialised expertise in the post-industrial era.

Meanwhile, at the theoretical level there has been increasing criticism of the individual leader as unit of analysis (Gronn, 2002). Hartley & Benington (2011) describe this as a move away from an era of the 'romance' of leadership, where heroic, charismatic individuals were considered necessarily beneficial to organisations. Grint & Holt (2011) similarly believe that the 'romance' era was mythical and even counter-productive, with individuals set up to fail: no one individual will have all the traits identified for effective leadership (Hartley & Benington, 2011). With the heroic model of leadership described as an aberrant development (Gronn, 2008), inherently weak, and unsuited for the demands of the contemporary organisation, a model of distributed leadership has been proposed as a response to individualistic weaknesses and as a means of tempering an inflated view of human agency (Gronn, 2008).

3.3.2 Distributed Leadership

Turnbull James (2011) summarises the three principle contentions associated with a distributed model of leadership:

1. That leadership involves multiple actors taking up leadership roles formally and/or informally, with leadership shared by collaborative working, often across organisational boundaries;
2. That leadership can be distributed away from the top of an organisation, with the potential for 'leaders at many levels' and new practices and innovations;
3. That leadership is about more than attributes and leader-follower relationships; it also involves leadership practices and organisational structures.

Distributed leadership, as a response to the problems associated with an individualistic approach, has been conceptualised by various authors. Yukl (1999), for example, defines distributed leadership in relation to no single individual being required to perform all essential leadership tasks in an organisation. Instead, a set of people is required, between whom all necessary leadership tasks can be undertaken collectively. Yukl offers several options within this conceptualisation of leadership, which may be employed at different times according to need. These include:

- Important decision-making shared by several group members;
- Some functions of leadership being allocated to individual members;
- Some functions being performed by different people at different times.

In Gronn's (2002) conceptualisation of 'concertive action', three models are described which appear on a continuum:

- Spontaneous collaboration, which may be regular and anticipated, or unanticipated; for example, the pooling together of expertise for a specific problem;
- Intuitive working relations; that is, the gradual formation of partnerships over time, in which close interpersonal relationships and trust are key;
- Institutionalised practices, which are seen in the tendency to institutionalise formal structures.

Fletcher (2004) believes a move towards a distributed model of leadership requires a re-thinking of various elements of leadership, the result being a paradigm shift in what it means to be a positional leader:

- From individual to collective;
- From control to learning;

- From self to self-in-relation;
- From power over to power with.

While a distributed model of leadership has been widely embraced as a more appropriate and realistic approach than the individualistic, heroic model, it is not without its challenges. Gronn (2008) believes organisations will need to consider what degree or level of distributed leadership they require, while Fitzsimmons *et al* (2011) point out that any transition to new models of practice in organisations can be challenging. They suggest there is a danger of paying insufficient attention to the emotional dynamics at play in shifts to alternative models of leadership, particularly within organisations that have tended towards hierarchical, managerial approaches.

3.3.3 The Place of Followers

Earlier leadership thinking has been accused of paying insufficient attention to the significance of followership (Grint & Holt, 2011), but with the advent of distributed models of leadership, and following a “tsunami of leaders gone wrong” (Bennis, 2008:4), interest in followers has grown (Avolio *et al*, 2009). Previously considered a homogenous mass, followers have now been re-conceptualised as “the anvil of leadership” (Grint & Holt, 2011). For example, Howell & Shamir (2005) describe how followers’ traits and characteristics influence relationships built between them and leaders, while Meindl (1985; 1995) writes of the impact of followers’ understanding of leaders, emphasising their role in determining the construction of leader identities.

Carsten *et al* (2010) describe the social construction of follower roles at the individual level, for example in terms of passive or challenging behaviours, showing the complexities of the follower role, and emphasising the importance of interplay between leadership styles, organisational climate, and follower behaviours.

Rost (1993) considers whether followership is in fact an outmoded concept, given the flattening of hierarchical structures in organisations, but Grint & Holt (2011) believe such hierarchies are alive and well, confirming the need to attend to the place of followership when considering leadership construction and enactment.

3.3.4 Transactional versus Transformational Leadership

A key element within contemporary leadership thinking has involved consideration of transformational and transactional approaches. Here, I offer a summary of the various benefits and challenges associated with both models of leadership and concludes with their relationship to contemporary thinking.

Transactional leadership has its roots in the 'bottom line' (Bolden *et al*, 2003:15), with principles based on the need to get a job done and make a living. The focus tends to be on tactical issues, short-term goals and hard data, and working effectively within existing systems (Covey, 1992). In a transactional model, the leader's behaviour represents an exchange, or transaction, between leader and follower, where the leader exchanges rewards for performance, effort and follower participation (Boseman, 2008).

Bass (1990) suggests that where the two distinctive transactional leader behaviours, those of contingent reward behaviour and management by exception, are demonstrated, then there is seen a consistent establishment of positive employee attitudes and behaviours. Here, there is recognition of the power associated with a reward system. However, Boseman (2008) believes that while transactional leader behaviours are capable of building trust between leaders and followers, followers will deliver no greater performance than is expected and rewarded.

On the other hand, Burns (1978) describes the concept of 'transforming' leadership, in which leadership is a mutually stimulating relationship between leaders and followers, and

where followers can be transformed into leaders, and leaders into moral agents. This occurs through a process of engagement between individuals, with leaders and followers raising one another “to higher levels of motivation and morality” (Bolden *et al*, 2003:14).

Bass (1985; 1990) develops Burns’ model of transforming leadership into one of ‘transformational’ leadership, where the leader transforms followers through several processes (Bass & Avolio, 1994):

- Idealised behaviours (living one’s ideals);
- Inspirational motivation (inspiring others);
- Intellectual stimulation (stimulating others);
- Individualised consideration (coaching and development);
- Idealised attributes (respect, trust, faith).

Through such processes, leaders act to increase awareness of what is right and important, raise motivational maturity, and encourage followers to go beyond their self-interests for the good of the wider organisation. Thus, followers are provided with a sense of purpose that goes beyond the simple exchange of rewards for effort provided, as espoused in the transactional model. There is the suggestion in transformational leadership, of a sense of generalised pro-activity: if leaders support the development, rather than just the performance, of followers, then they also optimise the development of the organisation, as high-performing employees help to build high-performing organisations (Bolden *et al*, 2003:16).

One of the main strengths of transformational leadership lies in its intuitive appeal – the image of a leader “out front, advocating change for others” (Northouse, 2007:191) is consistent with society’s popular notion of what leadership means. However, criticisms have been raised in relation to an emphasis on the visionary and charismatic elements of

the transformational leader's character, as there is the suggestion of a re-emergence of trait-based theories (Deckard, 2010:209). In other quarters, however, this criticism has been countered, with a call to differentiate between the concept of transformational and charismatic leaders. While transformational leaders are characterised by a tendency to empower others and work in partnership with followers, charismatic leaders are more likely to emphasise the need for radical change, which to be successful requires followers to put their trust in the leader's "unique expertise" (Yukl, 1999).

Bass (1990) supports this differentiation, with a strongly held belief that any individual within an organisation can be taught the principles of transformational leadership, suggesting that charisma might be thought of as a learned characteristic, rather than simply an innate one. Bass describes charisma in leadership as energy, self-confidence, determination and verbal skills, all of which he believes can be taught. From this perspective, charisma can be seen as just one element of the transformational leader's tool box, and one that needs to be put to work alongside the more follower-oriented behaviours, such as providing individualised support (Boseman, 2008).

A further defence of the transformational model is offered by Northouse (2007:191), who believes that, while there is undoubtedly an individualistic focus within this approach, there is also a strong emphasis on the needs and values of followers. Because the process of transformational leadership incorporates the needs of both leader and follower, leadership emerges as an interaction between the two, rather than being the sole responsibility of the leader. Further, there are suggestions that in successfully employed transformational models of leadership, followers are more satisfied, more optimistic, less likely to leave the organisation, more likely to trust the leader, and more likely to put in greater effort with consequently higher performance levels (Boseman, 2008).

While transactional and transformational models of leadership have at times been described in opposing terms, transformational leadership should not be seen as a 'panacea' (Bass, 1990). There are times when transactional leadership is entirely appropriate, for example when organisations are functioning in a stable environment, and in these circumstances a transactional model fosters good relationships between leaders and followers – which, like transformational leadership, results in high employee performance and satisfaction, and reduced employee turnover (Boseman, 2008; Bass, 1990). Circumstances should dictate which model is used to best advantage in organisations, with recognition that both styles have their benefits and challenges (Deckard, 2010:212). As discussed in relation to contemporary leadership thinking more generally, emphasis is placed on adaptive, fluid processes of leadership, rather than dichotomous models of thinking (Gronn, 2008; Yukl, 1999).

3.3.5 Leadership Conclusions

Leadership theoretical thinking can be viewed as an evolutionary process, which has reflected changes in organisational structures and wider social sciences philosophy. While earlier theory conceptualised leadership as trait-, behaviour- or situation-based, more contemporary thinking has espoused a more participative, distributed and team-based perspective.

Development in leadership thinking has resulted in a greater emphasis on the place of followers and the organisational context alongside the role of individual leaders. While there has been criticism of the continued individualistic focus evident in transformational leadership models, for example, there is strong evidence to suggest greater attention to interplay between leaders and followers, echoing the wider contemporary leadership perspective. Finally, there has been recognition of both transactional and transformational

models of leadership as valuable, notwithstanding criticism of the more typically hierarchical leadership styles seen in transactional approaches.

These developments in leadership thinking can be related to the theoretical framework of the study. While there is clear evidence of an individualistic focus to some degree, the place of organisational structures and groups of followers is also seen as central to successful leadership enactment. The role identity of leaders is significant, but the impact of wider structures and group interaction is always present. Thus, the study's framework incorporating both role and social identity in leadership identity construction and enactment is supported by contemporary leadership literature.

3.4 NHS Leadership

The review now turns to NHS leadership, in order to explore the context within which this study of identity construction has been undertaken. In this section of the review I describe the past and present of leadership in the NHS, and then move on to explore the recent focus on clinical leadership, including a rationale for its introduction and a review of studies involving clinical leadership within nursing and medicine.

3.4.1 A Brief History

In NHS leadership, there has been traditionally a focus on top management rather than attending to the significance of leadership at all levels of the organisation, a model of leadership now widely discredited (NHS Confederation, 2009). Such an approach, with a governance structure built on the principles of authority, control, tight performance management and accountability, makes the implementation of a purely transactional model of leadership almost inevitable (Millward & Bryan, 2005). An emphasis on managerial leadership goes "hand in hand with a set of seldom-questioned assumptions regarding the legitimacy and pervasiveness of hierarchy" (Edmonstone & Western, 2002),

and results in a view where middle and junior managers, and clinical professionals, are seen as dependent followers rather than leaders in any sense. As a consequence of this approach, employees develop a tendency to operate as if the structure and culture of their organisation are givens, and thus lose a sense of ownership in performing tasks (Millward & Bryan, 2005). There have been suggestions that this hierarchical model, where leaders fail to offer the degree of discretion and participation required by staff, is a central part of the conflict in the agenda for a better health service: the need to ensure staff remain accountable, but simultaneously allowing their creativity and participation to flourish (Firth-Cozens & Mowbray, 2001).

3.4.2 Transactional/Transformational Models in the NHS

NHS *management* quality has been described by the NHS Confederation (2007:3) as generally high, with managers committed to the NHS and passionate about their job, but the same authors describe *leadership* in the organisation as less consistent. Elsewhere, this disconnect has been ascribed to the NHS' approach to leadership, which has been described as "a largely remote 'managerial' phenomenon" (Millward & Bryan, 2005), in which decision-making and influence happen at some distance from the clinical frontline. Given the structure of the NHS, in which "the very transactional methods" (Firth-Cozens & Mowbray, 2001) of performance monitoring, clinical audit, league tables, controls assurance, for example, have been central, it is perhaps unsurprising that a transactional – or managerial leadership – model has gained primacy. Such methods of control make it difficult to achieve a transformational model of leadership (Firth-Cozens & Mowbray, 2001), despite suggestions of its effectiveness.

There have been suggestions that in fact, both transactional and transformational styles of leadership are required within health services, due to the amount of change regularly undertaken and the complexity of the organisation (Edmonstone & Western, 2002; Firth-

Cozens & Mowbray, 2001). Staff need an environment and structure in which they are able to both lead change and to hold things stable (Alimo-Metcalfe & Alban-Metcalfe, 2000), suggesting that a variety of styles and individuals may be suited to the many leadership requirements within the NHS.

These ideas relate well to the findings from the wider literature on leadership presented earlier, in which similar conclusions were drawn regarding the relevance and appropriateness of employing both transactional and transformational models of leadership, depending on circumstance and context. However, the NHS has historically operated under a transactional model, which has resulted in accusations of a command-and-control, bureaucratic approach to leadership in the organisation. Significantly, the hierarchical model of transactional leadership has been roundly criticised in recent high profile reports of systemic failures in patient care (e.g. Francis, 2013). At the same time, a focus on leadership by clinicians has been emphasised in government policy, particularly the Next Stage Review (2008) and the Health and Social Care Bill (2012).

3.5 Clinical Leadership

The next section of this review addresses the subject of clinical leadership, exploring its perceived advantages, the experiences of clinicians who have moved to leadership roles, and the significant challenges facing the NHS in embedding clinical leadership within the organisation.

3.5.1 Precursors to Current Thinking

The Griffiths Report of 1983 resulted in an ongoing debate about the need to improve NHS management and leadership (NHS Confederation, 2009). The post-Griffiths advent of general management was an attempt to make the professional domain subordinate to the managerial domain, representing adherence to a unitary rather than pluralist view of the

organisation (Edmonstone, 2008). The introduction of general managers meant a shift in power, as control was passed to managers alongside doctors, and doctors perceived a loss of autonomy. A further upset to the medical hierarchy was seen in the new ability for nurses to become general managers (Nicol, 2012). Next came the emergence of clinical governance in the late 1990s. Here, chief executives – and thus those accountable to them – became responsible for both the clinical and financial performance of NHS organisations. The result has been poor, or patchy, engagement between general managers and clinicians, with clinicians believing their views are not adequately listened to (NHS Confederation, 2007:8).

Further, a 'disconnected hierarchy' creates further division within the organisation: there has been a disjunction between those responsible for frontline management and those delivering frontline services. This results in an inverted power structure, where people at the 'bottom' of the organisation generally have greater influence over decision-making on a day to day basis, than those in control at the 'top' (Edmonstone, 2008; Nicol, 2012).

3.5.2 Rationale for Clinical Leadership

Current challenges of managing financial constraints and increasing patient expectations are the basis for the advent of clinical leadership (Nicol, 2012; Storey & Holti, 2013), although a more cynical view would suggest the dilution of distinctive professional values and cultural norms is a further motivation (Doolin, 2002; Storey & Holti, 2013; Phillips & Byrne, 2013). There are also suggestions that hybrid clinician-managers are able to act as translators and mediators, bringing management norms into clinical practice (BMA, 2012; Doolin, 2002).

The benefits of clinical leadership have been described in terms of both patient and staff outcomes. For staff, there is a greater degree of power and improved motivation (Murphy

et al, 2009; Fenton, 2012), while for patients there is better care delivery (Murphy *et al*, 2009; Phillips & Byrne, 2013). Certainly, recent reports have highlighted the devastating effects of a lack of effective leadership, including that delivered at clinical level (Fenton, 2012).

A rationale for clinical leadership in the NHS is clearly described in the Next Stage Review (DH, 2008). According to the NHS Confederation (2009), the report recognises that change delivery is not simply related to incentives, policy and competition, but also requires high-quality leadership at every level, across local systems, and particularly by clinicians. Various authors have highlighted the benefits of clinical leadership in relation to organisational performance. For example, Mannion *et al* (2005) looked at cultural differences between high and low performing health care organisations, and found that leadership was “of paramount importance”, with strong and empowered clinical leaders forming an essential part of this picture – although working as facilitators rather than as ‘enforcers’. Oliver (2006) believes clinicians able to show leadership and to act as role models are necessary at every level of health care organisations, if there is to be developed a dynamic and responsive system, with a workforce able to cope with frequent change, as seen in the NHS. Ham (2003) believes that well-developed systems of clinical leadership are the means by which to achieve effective change, particularly in view of the difficulties associated with general managers controlling medical work, while Oliver (2006) suggests that in recent years, there has been formal recognition of the role that nurses and allied health professionals can play in effective change, and thus become leaders within the organisation. As Millward & Bryan (2005) point out, 80% of all health care is delivered by nurses and midwives, making the advent of clinical leadership in these professions an unsurprising development in the NHS vision.

However, while clinical leadership has been widely welcomed in principle, various authors have described the complex and at times challenging nature of a hybrid clinical-managerial role. The next section of the review summarises the findings from studies within nursing and medicine, relating clinical leadership challenges to individual, professional group and organisational levels of analysis.

3.5.3 Individual-level Challenges in Clinical Leadership

Clinicians find a lack of role definition in management, compared with their clinical role, as well as an increase in pressure with little corresponding reward or recognition (Osborne, 2011). A further challenge is the impact of trying to maintain a clinical role while undertaking management tasks. Time pressures and a lack of management skills or appropriate education (Storey & Holti, 2013) can result in identity conflict, which in turn leads to decreased job satisfaction and organisational commitment (Kippist & Fitzgerald, 2009). On the other hand, moving away from clinical work altogether can result in a sense of loss (Ham *et al*, 2010). Clinical leaders have found that where leadership development opportunities are provided, there is often too much reliance on a skills, traits and competence-based model, with insufficient contextual learning (Howieson & Thiagarajah, 2011).

3.5.4 Group-level Challenges in Clinical Leadership

The group level analysis of challenges identified in studies of clinical leadership provides strong evidence of the professional-managerial conflict briefly described above. Problems are identified in both inter- and intra-group relationships, and relate to the complex history of interactions between professional groups, and between clinicians and general managers (Dopson & Fitzgerald, 2006).

The basis for conflicts of identity can be found in the perceived differences between clinical and managerial foci. In terms of leadership, clinicians tend to have a micro-view focus on patients, client groups and services, whereas managerial leaders typically focus on the overall needs of the organisation (Edmonstone, 2005). This difference is based on two different sets of values, which hybrid clinical leaders have to span – referred to by Kippist & Fitzgerald (2009) as the intersection of the practice and business of health.

Studies of clinical leadership have generally found a tendency for clinical leaders to maintain a professional identification in their leadership and management roles (Ham *et al*, 2010; Iedema *et al*, 2004; Doolin, 2002; Hoff, 1999). Hybrid leaders see their professional identity, based on devotion to service, as superior to a management identity, based on politics and the bottom line (Hotho, 2008). At the same time, however, they face rejection by their own professional group as they are perceived as having moved to ‘the dark side’ (Ham *et al*, 2010). Hoff (1999) found a decreased group cohesion associated with clinicians moving to managerial roles, where they were faced with conflict, distrust, anger and resistance from members of their professional group. Hoff believes this is due to even hybrid clinician-managers being seen as a deviant group culture. The desire to maintain a professional identification among clinical leaders is also described by Hekman *et al* (2009), who suggest a tendency among clinicians to resist control by those they perceive as non-clinicians, which would again add to a sense of conflict within the professional group.

Credibility is a key issue at the individual and group level of analysis in clinical leadership. At the individual level, clinical leaders have suggested a sense of loss in leaving clinical practice, related to both patient and colleague relationships (Ham *et al*, 2010). At the group level, a study by the British Medical Association (BMA, 2012) found that the main enabling factor in clinical leadership was peer support. Similarly, Doolin (2002) found validation of a hybrid clinical-managerial role could be seen at individual and group levels.

At the individual level, one's own perception of the degree of control in career decision-making was highly significant, while at the group level, validation occurred through clinicians' acceptance of the hybrid identity. However, Osborne (2011) found that clinicians hold highly negative views of clinical leaders who do not hold a clinical caseload.

There is further evidence of group-level conflict, in relationships between clinical and general managerial leaders. Edmonstone (2008) relates this to different leadership styles; while clinical leaders tend to subscribe to a 'reflective practice' or 'professional artistry' philosophy, where change is incremental, non-clinical leaders show more of a 'big bang' approach to change. Edmonstone goes on to suggest that non-clinical leaders need to recognise clinical leaders' attachment to more shared and distributed models of leadership, otherwise there is a risk of widening the gulf between the two groups. Friction between clinical and general managerial leaders also tends to be based on perceived language barriers and differences in power structures (Ham *et al*, 2010; Nicol, 2012). However, there have been suggestions in the clinical leadership literature of benefits between the two groups. Ham *et al* (2010), for example, found that doctors were able to value working alongside non-clinical leaders; while Hoff (1999) found that clinical leaders with a strong professional group identification felt little sense of division from general managers, as they perceived them as a separate group doing a different job.

While boundary-spanning clinical leaders encounter many challenges in their identity construction and enactment, they have found ways of managing potential conflict. Hotho (2008) found that doctors in clinical leadership roles created a 'hybrid professionalisation' – a new in-group, where boundary-spanning was seen as being *within* the clinical group. Iedema *et al* (2004) found that hybrids existing at the boundaries of several discourses did not settle on any single discourse, which gave rise to the possibility of a more fluid view of clinical leadership, away from the dichotomous view of allegiances more typically

described. Other authors support this idea: Kippist & Fitzgerald (2009) suggest the key challenge in clinical leadership is maintaining and demonstrating commitment to both profession and organisation, while Ham *et al* (2010) believe there is the possibility of plurality rather than duality within clinical leadership roles.

3.5.5 Organisational-level Challenges in Clinical Leadership

The challenge for organisations lies in enabling and supporting the development and enactment of clinical leadership roles. Fenton (2012) writes of the importance of a whole organisation approach in enabling clinical leaders to maintain a clinical presence, which as I described above, is significant at both individual and group levels. Fenton suggests that currently, organisations place too much emphasis on the managerial aspects of clinical leadership roles.

There have also been suggestions that NHS organisational structures have not supported the development of clinical leadership careers (Ham *et al*, 2010; BMA, 2012). Various studies have found deficiencies in clinical leadership development; for example, development programmes have been poorly timed in terms of career trajectory (BMA, 2012; Osborne, 2011; Phillips & Byrne, 2013); development has been delivered away from the clinical frontline, and has involved teaching models of leadership rather than clinical realities (Phillips & Byrne, 2013); access to development has been highly variable (Ham *et al*, 2010), and at times inadequate for the role of hybrid clinical-managerial leader (Iedema *et al*, 2004; Hoff, 1999). Storey & Holti (2013) describe this inconsistent approach as ‘schizophrenia’ on the part of the NHS, in which the organisation says it wants to develop clinical leadership careers but then acts in direct opposition to this aim.

This evolution in NHS leadership thinking has been described in relation to the development of a new discourse, one in which ‘management’ has been re-labelled as

'leadership', having originally been known as 'administration' (Martin & Learmonth, 2012). Here, the central focus becomes 'the establishment of a passion for a common goal between leaders and led' (O'Reilly & Reed, 2010), where leaders take responsibility for policy level reforms, and policymakers are seen as mere 'translators' of the decisions of multiple, distributed groups of leaders. Management is re-conceptualised as the weak practice of compromise, more akin to 'administration' (Martin & Learmonth, 2012).

While this discourse change has been widely introduced across public sector organisations (Currie *et al*, 2009), there has also been criticism of such an approach. Currie & Lockett (2011) describe the risks of behaving as though leadership is the 'panacea' to improve performance, while Martin & Learmonth (2012) describe a return to an heroic model of leadership, writing that in fact, leadership in such terms might be described as 'a nefarious political project', through which subtle forms of control are facilitated.

The dangers of this individualistic approach to the change leadership required by policymakers is highlighted by Fitzgerald *et al* (2013). Their study, looking at hybrid clinician-managers and the progress of specific change initiatives, found that the most successful examples of change leadership occurred in a distributed pattern of leadership. Here, service improvement was enabled by widely distributed leadership, where hybrid professionals had a core role as boundary spanners, and there existed good foundational relationships.

At the same time as policymakers are advocating a distributed model of leadership, some authors have highlighted a paradox, due to the simultaneous shift towards a centrally driven agenda of performance management and strong governance (Martin & Learmonth, 2012). Currie *et al* (2009) describe this in terms of a 'Catch-22' for public sector leaders, and describe the possibility of only a 'weak' version of distributed leadership in the face of such contradictory pressures.

3.5.6 NHS Leadership Conclusions

In recent years, the NHS has moved to embrace a less hierarchical, more clinically-oriented model of leadership. However, given the long history of top down, command-and-control leadership within the organisation, it is perhaps unsurprising that clinical leaders face a number of significant challenges. As in the wider leadership literature, there are clear links to be seen with the study's theoretical framework when examining clinical leadership. The interaction between individuals, professional groups and organisational structures in clinical leadership is well-described in the relevant literature, as I summarised above. However, there has been a tendency in studies of nursing and medical clinical leadership to under-theorise questions of role and social identity. The study's attention to individual, group and organisational levels of analysis is a timely and appropriate addition to existing literature.

The emphasis on the place of narratives in identity construction is also highly relevant in the context of NHS clinical leadership roles. As I have described, there are a number of challenges to the narrative identities of individuals making the transition from clinical to leadership and management roles, and these can be described in terms of discourses at individual, professional group and organisational levels. The exploration of individual midwifery leaders' identity work in negotiating these various discourses offers an analysis that incorporates micro and macro levels (Chreim *et al*, 2007).

3.6 Leadership in Midwifery

Midwifery is the specific focus for the study, and there now follows an explanation for this approach. I offer a brief history of the profession, in order to explain how midwifery has evolved over the past century, and I follow this with an exploration of current issues within the profession's leadership and an overview of recent initiatives within the field.

3.6.1 A Brief History

A succinct description of the impact of various significant reports, from within and beyond midwifery, is provided by Ralston (2005):

- The first Midwives' Act of 1902 improved standards of care, but had far-reaching implications – a regulating and controlling approach led to the role of the inspector, now known as the supervisor of midwives, overseeing practice;
- With the advent of the NHS in 1948, midwives became salaried servants of the state, while GPs were offered extras payment for the provision of antenatal care. The result was that women had direct access to GPs rather than midwives. With the GP now being the first contact for pregnant women, there was a permanent alteration to midwifery control over maternity care (Oakley, 1986:143);
- Salmon's (1966) midwifery hierarchy promoted a top-down management approach and led to midwives occupying management positions without prior preparation;
- The Peel Report (1970) has been linked to the medicalization of childbirth, with its perceived recommendation that birth should take place in the hospital setting; the male medical model was seen as scientific and factual, and superior to female intuitiveness and experience; there followed a downward spiral of low self-esteem, reduced initiative, and reduced assertiveness among midwives;
- The Briggs Report (1972) led to the amalgamation of nursing and midwifery, and a resultant loss of professional identity for midwives that is still in evidence today; midwifery has been frequently under-represented, or represented by nursing;
- The emergence of general managers following the Griffiths Report (1983), where general managers became line managers to midwifery and nurse managers, and in some cases midwives became managed by nurse managers; there continued a model of top-down management and centralised control, as described earlier.

From this description of midwifery history, the profession has seen a struggle to retain its professional identity as the expert practitioner in normal childbirth, which is unsurprising given the way midwives have been subsumed from three distinct angles: the medical model of childbirth, where birth is regarded as normal only in retrospect; the nursing profession, which holds an essentially different philosophy from the 'birth as a normal life event' model of care delivered by midwives; and the general managerial model within the wider NHS, to which I referred earlier in this chapter, and which has resulted in problems for all the health care professions in relation to a perception of loss of autonomy and control.

Within midwifery, there have been suggestions that the profession has overly relied on external validation, resulting in little independent voice remaining, and a consequent turning on each other rather than uniting behind the common goal of midwifery, that of quality care (Gould, 2005). Meanwhile, the Department of Health (2009:32) now recognises that a lack of representation by midwives at a senior level in some NHS trusts may have contributed to poor quality of care, an acknowledgement of the important knowledge that midwives hold within their profession.

3.6.2 Current Issues in Midwifery

In 2007, the Department of Health published 'Maternity Matters: choice, access and continuity of care in a safe service'. A key statement within the document reads:

"It is imperative that organisations have good leadership, within an open and supportive culture which will provide the foundation for good maternity services that can fulfil the needs and expectations of women and their families. Organisations will need to consider the level of investment required to build and enhance leadership that will also support job satisfaction and staff morale" (p24).

Ralston (2005) agrees that, in a government vision of a patient-centred health service, midwives must be developed and supported to become future leaders. However, she goes on to argue that there has been little evidence of the encouragement of midwives with leadership potential, describing the NHS as an organisation which rewards conformity rather than innovation, and referring to the same rigid systems so heavily criticised in recent reports of failures of care. Meanwhile, Coggins (2005) describes how government challenges to improve standards and strive to meet increasing public demands have led to an expansion of the midwife role to include a focus on public health, and clinical responsibilities formerly in the medical domain. She associates this with an increased risk of litigation, and consequently a culture of defensiveness, unrest and instability among midwives.

While the Department of Health (2009:33) describes the development of leadership capabilities in the midwifery workforce as “a high priority”, and suggests that midwives should gain access to existing and new development opportunities in the NHS, Ralston (2005) believes the challenge for the NHS lies in *how* midwives will be developed and equipped with the skills that will enable them to lead at clinical, organisational and national levels.

3.6.3 The Case for a Midwifery-focused Study

Midwifery leadership has been identified as an area of significant importance in government-level documents. As I described earlier, Maternity Matters (DH, 2007) highlights the value of strong and effective leadership in relation to placing the midwife at the centre of all women’s care. Meanwhile, ‘Midwifery 2020: delivering expectations’ (DH, 2010) emphasises the importance of timely and appropriate development for midwives choosing leadership and management career options. Such policy documents echo the wider public services literature identified earlier, relating to the ‘rise of leadership’ (Martin

& Learmonth, 2012), and the complexities of a leadership rhetoric in the context of increased centralisation, governance and control (O'Reilly & Reed, 2010; Currie *et al*, 2009).

While midwifery was not specifically identified as problematic within the Francis Report (2013), concerns have been raised about the profession in the aftermath of devastating events in other cases. The Healthcare Commission (2006) investigated a number of maternal deaths at Northwick Park Hospital, and found poor communication between midwives and obstetricians, as well as “deficiencies in the management structures” contributed to the poor quality of care the women received:

“For example, midwives were expected to manage a busy delivery suite that was reliant on agency and locum staff, with at times, little professional or managerial support” (p6).

Similarly, the Fielding Review (2010), an external review of University Hospitals of Morecambe Bay maternity services commissioned by the trust following five maternity serious untoward incidents during 2008, found a deficit of inter-professional and clinical-managerial communication. The review suggested there was:

“A requirement for staff of all disciplines to cooperate in working together harmoniously, and for management and staff to develop a greater sense of trust in their relationship” (p2-3).

A third case, based on several neonatal deaths and general public concern in relation to safety and quality of care at New Cross Hospital in Wolverhampton, prompted an investigation into maternity service provision by the Healthcare Commission in 2004. Their findings singled out leadership and management:

“The investigation also found problems around the leadership and management of the maternity services, team working and staffing. The leadership at all levels in

the maternity services, and in the women's and children's division appears to have been weak and inconsistent for several years... The relationship between the Head of Midwifery, Clinical Director and Divisional Manager did not allow for effective leadership and management" (p6).

It is clear from these reports that midwifery leadership has been an area of concern for several years. A further issue within midwifery is the ageing workforce, highlighted in Midwifery 2020 (DH, 2010) and 'Towards Better Births: a review of maternity services in England' (Healthcare Commission, 2008). According to Midwifery 2020, 40-45% of the midwifery workforce is within ten years of retirement; two-thirds of the workforce is aged over 40; and one quarter of the workforce is aged over 50. In 'Towards Better Births', the Commission identified similar facts, adding that there was wide variation between maternity units in relation to age of staff, and suggesting that some units are not paying sufficient attention to forthcoming problems with senior midwives retiring. These figures give greater emphasis to the significance of developing the next generation of midwifery leaders, as the majority of the profession's leaders are likely to be in the older age groups.

At (former) strategic health authority level, there has been recognition of the need to develop the next cohort of midwifery leaders. NHS Midlands and East commissioned several leadership development programmes during 2007 to 2009, which were aimed at developing clinicians at various levels within the organisational hierarchy; meanwhile, the Royal College of Midwives runs a strategic leadership programme for senior clinical leaders.

While midwifery has been identified as a profession in need of development at policy level, the profession is also of interest in relation to the study's theoretical framework. For example, social identity theory would suggest challenges in terms of individuation, with midwives separating themselves at group level from obstetrics, nursing, and general management. From a de-individuation perspective, a continued professional identification

among midwifery clinical leaders would echo the challenges of clinical leadership identities seen in published research among nurses and doctors. From a role identity perspective, the interaction between midwifery clinical leaders as agents and the wider organisational structure is of interest.

Given the concerns identified above, and echoing the experiences of doctors undertaking hybrid roles, it is to be expected that midwives will need to undertake significant identity work in their attempts to negotiate problematic discourses between professional group and organisational structure. The theme of narrative identity running through the study will enable analysis to include attention to this identity work, and strengthen the theoretical contribution the research may offer.

Finally, midwifery leadership is an under-researched area. While there have been studies of clinical leadership in nursing and medicine, as outlined earlier in this chapter, midwifery remains almost unmentioned. During the literature search for this study, only one empirical work within midwifery was discovered. That study (Byrom & Downe, 2008) does give some attention to midwifery leadership, but is focused on what characteristics make a 'good' midwifery leader, rather than examining the challenges facing those who move from clinical to leadership roles. Given the attention focused on midwifery leadership recently, as outlined above, the profession offers a rich field for exploration of identity construction and enactment in clinical leadership.

3.7 Chapter Conclusions

Leadership theory has evolved from ideas of traits, characteristics and behaviours to an approach which regards followers and organisational context and structure as equally important. Contemporary theory sees leadership as a fluid, adaptive process of attributed influence rather than as a fixed set of skills. Significantly, distributed models of leadership

embrace ideas of leadership at every level of an organisation, based on contemporary organisational structures and a move away from dichotomous thinking more generally.

The link between leadership and the study's theoretical framework is clear: an individualistic focus is insufficient when considering identity construction within leadership, with evidence suggesting a powerful interaction between leaders, followers and organisational structures.

In the NHS, leadership thinking has recently been moving away from a managerial, top-down, hierarchical model of leadership development and enactment, evident in the advent of clinical leadership, with its principles of leadership at every level. However, clinical leadership has an added complexity of involving groups with strong professional identities, and literature in this area has identified a number of challenges. Alongside this complexity, there is the paradox described earlier in this chapter, where alongside a stated desire to increase the distribution of leadership across the organisation, NHS policy simultaneously appears to suppress the likelihood of distributed patterns of leadership due to an increasingly centrally driven programme of performance management and governance (Martin & Learmonth, 2012; Currie et al, 2009; O'Reilly & Reed, 2010).

Again, the link with the theoretical framework is clear: clinicians make the transition to a leadership role in the context of two significant factors:

1. An organisational structure that has traditionally employed a top-down approach to development and enactment of a managerial model of leadership, which is at odds with the principles of clinical practice;
2. The potential conflict inherent in enacting leadership in a hybrid professional-managerial capacity.

Thus, in clinical leadership complexity exists at individual, professional group and organisational levels.

Finally, the case of midwives is interesting at two levels. First, as a professional group within the NHS organisational structure, midwifery can be explored in relation to a theoretical-level analysis of clinical leadership; and second, as a professional group with a problematic history and much recent attention in relation to future leadership, the study adds to an extremely sparse body of knowledge in this area. The literature review chapters have provided a justification for both of these elements of the study.

Chapter Four: Methodology

4.1 Introduction

In this chapter, I address issues of methodology, methods, and analysis of the data. A full description of the methods employed follows, along with justification for the use of each element. I then address issues of methodological rigour, in order to demonstrate the degree of reflexivity applied to every stage of the study.

4.1.1 The Study's Purpose

As detailed in the previous two chapters, the theoretical position of the study relates to the interplay between 'me' and 'we' states in clinical leader identity construction and enactment, with the midwifery profession being used as the empirical focus, and within the context of NHS policy suggesting the importance of transformational, distributed models of leadership.

I suggest an exploratory approach to the study, which is reflected within the research questions:

1. How do exogenous and endogenous factors influence the transition to and enactment of leadership among midwives?
2. What are the development needs of midwives to promote new ways of working and drive system-wide change in the NHS and how might these be achieved?

The rationale for the exploration of exogenous and endogenous factors in clinical leadership reflects the significance of attending to interaction between individual, group and organisational levels of analysis identified in the previous two chapters, both contextually and theoretically. In this chapter, I explain how that holistic approach was

translated into a research design, and what impact it had on questions of methodology and method in the study.

4.1.2 Chapter Organisation

The chapter proceeds as follows: first, I address issues of ontology and epistemology in relation to the study, and I explain how these were pertinent to all areas of the research design. Next, I explain the rationale for a qualitative design, and justify the use of a case study and narrative approach. Subsequent sections deal with the specific methods employed for data collection and analysis, along with consideration of ethical issues. Finally, I address the central question of achieving rigour in a qualitative research study, including attention to issues of credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985; Bloomberg & Volpe, 2008).

4.2 Philosophy

4.2.1 Overview

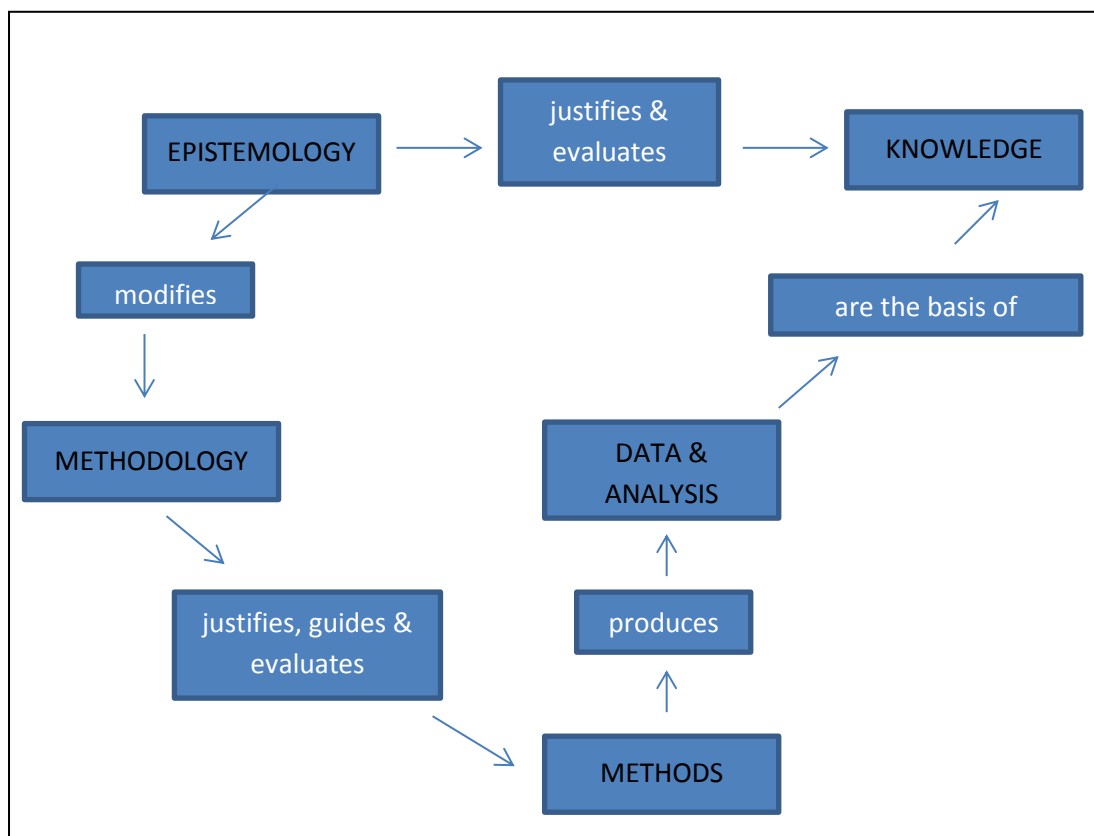
On a personal level, I have long espoused an interpretivist worldview, although only through study at Masters level was I able to give it a name. This is not to say that I do not recognise value in a more positivist paradigm – as a reflective thinker, it would be counter-intuitive to ‘rubbish’ an alternative perspective. Weber (2004) provides a useful argument here, suggesting that positivist and interpretivist paradigms are not so polarised as is often suggested. As he puts it,

“I no longer want to be labelled as positivist researcher or an interpretivist researcher. It is time for us to move beyond labels and to see the underlying unity in what we are trying to achieve via our research methods. The commonalities in my view are compelling and paramount. We ought to celebrate them because they

underpin the value of our role as scholars. The differences, on the other hand, are ancillary. We should understand them, but they should not divide us”.

However, the principles of positivist and interpretivist research will have an impact on the epistemological, methodological and methods choices made by researchers (Weber, 2004), for example in whether textual or numerical data will be used, and how a researcher might see herself as a research instrument, with the consequences arising from such an approach. In this study, a decision needed to be made about methodology early on in the process, due to the rigours of gaining ethical approval and because I needed to be clear with the leadership development programme delegates about what my approach to the study would be. As Weber suggests, I have in the past embraced both quantitative and qualitative approaches to research design and execution, but in this case an interpretivist approach was my guide, which will be explained in greater detail in the coming paragraphs.

Fig 4.1: Epistemology, Methodology & Methods (Carter & Little, 2007)



4.2.2 Epistemology

Epistemological stance relates to assumptions, whether explicit or implicit, about the nature of knowledge (Oliver, 2004:123). The significance of this relates to the importance of linking epistemology with methodology and research methods, as the elements together provide a framework for the design, implementation and evaluation of quality in a research study (Carter & Little, 2007). Key decisions need to be made in the process of linking epistemology, methodology and research methods, as a well-designed study will demonstrate internal consistency between the elements (Carter & Little, 2007), as shown in figure 4.1 above.

My epistemological leanings are towards social constructionism, which is closely linked to the interpretivist ontological position. As Gergen (1999) suggests, I tend towards the idea that reality is socially constructed by and between the persons experiencing it, and is based on individuals' unique understanding of the world and their experience of it (Berger & Luckmann, 1966). This view offers a contrast with a positivist paradigm, where reality is considered universal, objective and quantifiable (Darlaston-Jones, 2007).

I used the general assumptions suggested by Burr (1995:2-5) when considering my epistemological position, and concluded that the strong interaction between individuals and others suggested in social constructionism was also significant in the study. The following are the key assumptions associated with social constructionism (Burr, 1995:2-5), and these acted as a guide throughout the research design process:

- A critical stance toward taken-for-granted knowledge – others' and our own;
- Our understanding of the world, the categories and concepts we use, as historically and culturally specific;
- The belief that knowledge is sustained by social process;

- The belief that knowledge and social action go together.

A social constructionist perspective is valid in the study, for two reasons: first, I was exploring an area where the 'reality' of identities is clearly socially constructed, there being no objective 'leader' identity to be quantified, with literature suggesting vastly different assumptions in various areas about what it means to be a clinical leader in the NHS. Second, role and social identity theories suggest the central role of interaction in the construction of identity, supporting the idea that interaction between people at specific times and in specific cultures impacts on identity construction and enactment (Darlaston-Jones, 2007; Burr, 1995).

4.3 Methodology

4.3.1 A qualitative approach

Qualitative research methodologies are associated with a social constructionist epistemological stance (Darlaston-Jones, 2007), as qualitative methodologies are concerned with how individuals make sense of the world, and thus the quality and texture of experience rather than cause-effect relationships (Willig, 2001:9). Further, qualitative methodologies are related to 'discovery' research, where complexity and context are considered central, and experience is viewed holistically, with those studied able to speak for themselves (Wilson, 1998:4).

In this study, I aimed to take a holistic view of the construction and enactment of a clinical leader identity, exploring the issue from multiple perspectives, as described in the theoretical and contextual literature chapters. Further, there has been scant attention to leadership within midwifery research, and the study offered the opportunity to explore an almost untouched area, so a 'discovery' approach was entirely suitable. Given the exploratory nature of the work, and my own beliefs about the nature of knowledge, I

considered a qualitative approach best, particularly in light of Carter & Little's (2007) suggestions about the integration of epistemology, methodology and methods.

Having explained the decision to apply qualitative methodologies to the study, I now turn to a description of and justification for the guiding methodologies: qualitative case study research, and narrative inquiry. At the end of this section of the chapter, I provide a revised version of the Carter & Little (2007) framework shown in figure 4.1 above, in order to demonstrate the connection between the chosen epistemology, methodology and research methods in the context of this research study.

4.3.2 Case study research

Case study research is considered an appropriate methodology where a rich description of a scene is required, in order to reveal the deep structures within social behaviours (Dyer & Wilkins, 1991), to unravel complex social phenomena (Yin, 2009:4), and to gain an understanding of how the parts of a situation or phenomenon affect each other. This study, as evidenced in the literature review, concerned a complex situation, as clinical leadership has many aspects that need to be unravelled; for example, the place of transformational leadership in a transactionally-organised organisation, the challenge of maintaining a clinical identification, and the complex interactions between and within groups in the NHS. An holistic approach, associated with case study research (Flyvberg, 2006; Yin, 2009:4), enabled me to look at the experience of clinical leaders in midwifery, through detailed exploration of several leadership programmes which I will describe in depth later in this chapter.

Case studies are also considered appropriate when little is known about a phenomenon (Eisenhardt, 1989; Denscombe, 2007:36), very much in keeping with the rationale I offered in relation to the adoption of a qualitative methodology more generally. As I described

earlier, midwifery has been largely neglected as an area for leadership study, despite relevant concerns having been raised in recent reports. Also, the study aimed to extend ideas of the integration of role and social identity into the field of NHS clinical leadership, again an area not yet fully explored at the theoretical level.

The final justification for the use of case studies relates to the idea that they can act as exemplars of a new paradigm in the Kuhnian sense, acting as examples of new relationships, orientations or phenomena which have yet to be captured by theoretical perspectives (Dyer & Wilkins, 1991). Moving beyond the specific case of midwives, this is certainly the case more generally in clinical leadership: clinical and distributed leadership are relatively recent ideas to be implemented within the NHS, and having identified the significance of adopting an holistic approach to exploring clinical leadership from role and social identity perspectives, case study research appears a useful means of gaining the depth required to achieve a deep understanding of the relevant issues.

It is important that I address potential weaknesses associated with a case study approach, having identified it as a generally appropriate methodology for the study. The methodology has its champions and its critics, as all methodologies do. Its defenders support the principles of in-depth investigation and the holistic approach inherent within case study research (Robson, 2002:180; Flyvberg, 2006; Yin, 2009), in answer to criticisms that the approach offers depth at the expense of breadth. While there has been criticism of the case study methodology per se (Yin, 2009:6; Robson, 2002:179), issues of rigour and subjective bias are not dissimilar to those levelled at qualitative methodologies more generally. Issues of methodological rigour will be addressed later in this chapter, in relation to the design and execution of all areas of the study.

While a case study approach provides a framework for the research, the question of narratives and their place in this research needs separate attention.

4.3.3 A narrative framework

Described as a “field in the making” (Chase, 2005:651), narrative inquiry is guided by several fundamental beliefs:

- That people’s accounts of themselves are storied, and the social world is also storied;
- That narrative is a key means through which people produce an identity;
- That narratives link the past to the present;
- That there is no unbiased account of the past (Lawler, 2002).

There is a holistic value inherent in eliciting narratives, as through telling their stories individuals demonstrate clearly their connections with the social, cultural and institutional environment around them, thus capturing both the individual and the context (Moen, 2006). This last point emphasises a clear link to the constructionist epistemological stance I have taken in the study, particularly in relation to its exploratory nature.

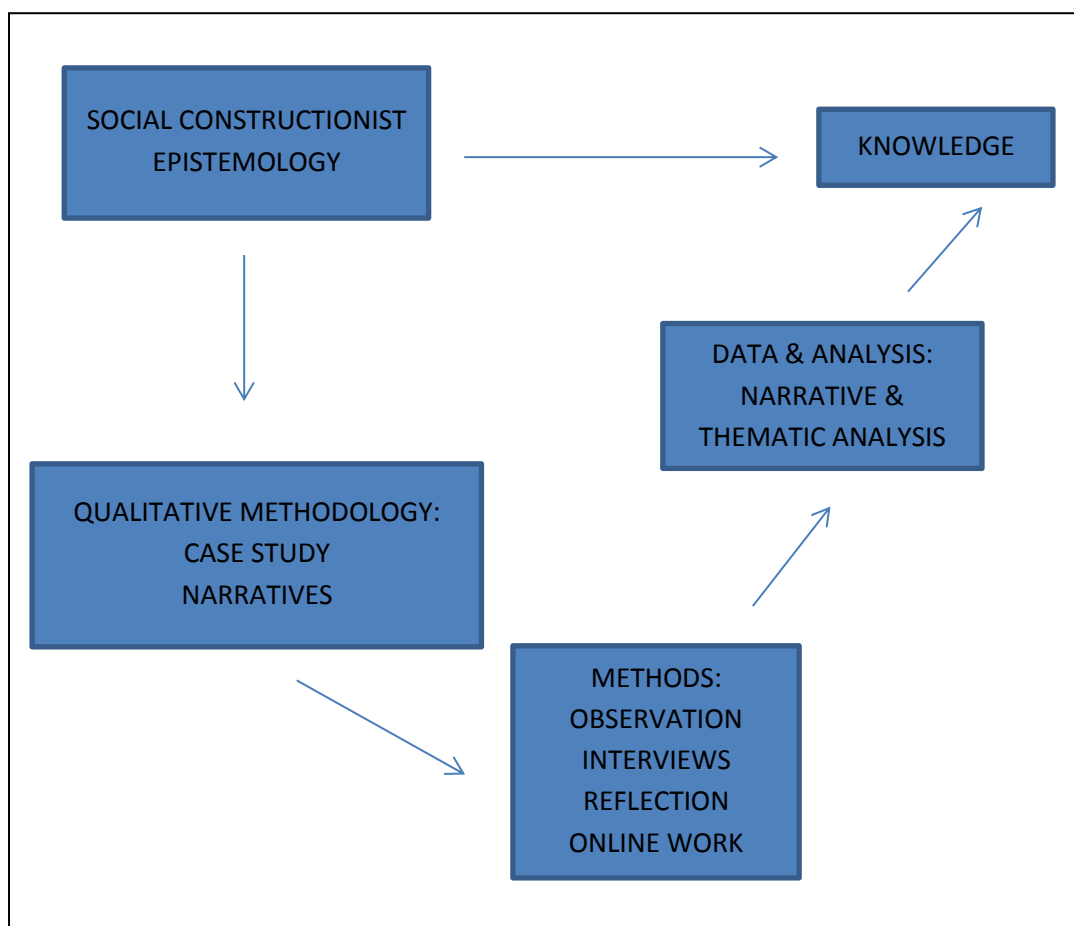
A narrative approach to the study was employed in relation to both the observation and interview elements of the study. This approach relates to three benefits associated with narrative inquiry: first, narratives facilitate the in-depth approach taken to the work (Greene, 1994); second, narratives are closely related to real-life experience, which was part of what I was keen to capture (Lieblich, 1998:5); and third, narratives have been described as a fundamental communication method through which our experiences, interpretations and priorities are revealed (Grbich, 2007:124), so I was hopeful that the approach would reveal much of the complexity of the factors influencing a transition to leadership, both endogenous and exogenous.

4.3.4 Summary

I have offered explanations of and justification for the study's methodological approach, based on ontological and epistemological principles, and in relation to the aims and objectives of the research. Figure 4.2, below, shows a revised version of figure 4.1, to demonstrate how the epistemology and methodology relate to the study's methods, which will be addressed later in the chapter.

The next section concerns the research sample, describing the strategies adopted for the selection of cases, interviewees and sites for online interaction.

Fig 4.2: Revised Epistemology, Methodology & Methods (Carter & Little, 2007)



4.4 The Research Sample

4.4.1 Overview

The importance of giving attention to sampling has been stressed, due to its profound effect on the ultimate quality of the research (Seawright & Gerring, 2008; Stake, 1994:243). Flexibility is required, however, when considering sampling methods, in order to permit adequate and appropriate exploration of the phenomenon under study (Lincoln & Guba, 1985). According to some authors, it is this very flexibility, associated with sampling procedures in qualitative studies, which may lead to confusion and mistakes (Morse, 1999; Coyne, 1997).

As I will describe in the following section, the selection of cases in this study was based on a mixture of purposive, pragmatic and serendipitous factors. The central method of sampling was purposive, which has been described as appropriate in case study research, due to the need for a sample which is 'information-rich' (Patton, 1990:169), and through which a great deal can be learnt about issues of central importance to the study. There has been criticism of the potential subjectivity inherent in purposive sampling (Oliver, 2004:128), so a clear justification is presented here in relation to the process through which cases were selected.

What follows is a narrative of the selection of cases for the study, followed by information about selection of interviewees from the cases, and the further selection of a sample within online midwifery forums. A rationale for each selection area is offered.

4.4.2 The cases

The research study was initially conceptualised as one involving leadership development in nursing, midwifery and the allied health professions. As an ESRC-funded case studentship, the proposal had been submitted and approved in advance of my involvement. During the first couple of months of the doctorate, I met with the non-academic supervisor, who was the leadership lead within the local SHA. During our discussion about potential cases

through which I could collect empirical data for the study, he made me aware of two leadership programme which were either in progress or about to begin. One of these was called 'Aspiring Heads of Midwifery' (working title) and was then in the planning stages. As a former midwife, I was naturally interested in this programme, but was aware that I should be thinking beyond my 'midwife' identity and looking more widely at potential cases. The other case mentioned at that time involved nurses, midwives and allied health professionals, and was aimed at Agenda for Change band 6 staff. It quickly became apparent that there was another doctoral student interested in observing this programme, and so my initial focus fell on the midwifery programme.

As the midwifery leadership development programme (case 1) was then in its planning stages, I was invited to attend meetings involving Arup consultants (who were the designers of the programme), relevant SHA employees, and two Heads of Midwifery helping to drive the programme forward.

I established a rapport with two Arup consultants, who were interested in my research, and they informed me of two further midwifery leadership development programmes underway in a neighbouring SHA. One of these programmes, like the Aspiring Heads of Midwifery, was aimed at midwives already in leadership positions (case 2 - Supervisors of Midwives, Matrons, and Heads of Midwifery), while the other was for midwives at bands 6 and 7 (case 3 - clinicians, and those with some management element to their role).

Realising that there were several programmes involving a specific midwifery focus, I did two things. First, I began to look at midwifery literature, in order to discover why there might be a sudden focus on leadership development. And second, I discussed with my academic supervisors the idea of focusing in on midwifery alone for the case study. During a review of literature around NHS leadership more generally, and based partly on my understanding from clinical life, I had identified that issues in clinical leadership might be

different between nursing, midwifery and allied health professional groups, and it might be unhelpful and impractical to group the various professions together.

As described in the contextual literature review chapter, there was good reason to develop leadership in midwifery, which was what the leadership programmes were reflecting. Once the decision had been made to focus the study on midwifery leadership, I began to look at other programmes that might be relevant to the research.

I made contact with the education lead at the Royal College of Midwives (RCM), and arranged to meet with her to discuss the possibility of using their strategic leadership development programme as a case within the study. When we met, I was told that observation of this programme would not be possible; the education lead was concerned that my presence might have a detrimental effect on the programme delegates, as they often found the programme emotionally draining. She did, however, put me in touch with a practice development matron (PDM) at a London hospital, where the RCM was working in partnership on a further midwifery leadership development programme. After meeting with the PDM, and discussing the case with my supervisors, I decided not to pursue that case, as the programme had recently finished, so there would be only documentary evidence rather than opportunities for observation of the programme in progress.

I then met with the leadership lead in the second SHA mentioned (cases 2 and 3), and discussed the proposed study. She was enthusiastic about my involvement, and suggested I would be made welcome as an observer at their two midwifery programmes. However, it turned out to be far more complex than this. Initially, access to study days and other leadership events in relation to cases 2 and 3 was unproblematic, but over time the issue became more difficult, as the SHA expected payment for my presence. Despite the intervention of Arup consultants, I eventually had to discontinue observing cases two and

three, and was left with complete access to case one. **Appendix 1** gives details of the three central cases involved, as well as details of the London case.

There has been much debate about whether a single or multiple case approach is preferable in this methodology, and it seems there is no consensus on the issue. The rationale suggested for the use of a single-case approach refers to the opportunity to gain a deep understanding of a complex, rare or extreme phenomenon (Dyer & Wilkins, 1991; Eisenhardt & Graebner, 2007). While Yin (2009:47-49) describes a variety of circumstances under which a single-case approach might be adopted, he goes on to warn that it may be vulnerable to unexpected outcomes – a case might not turn out to be the case the researcher was expecting – and there may be problems inherent in defending theoretical generalisability from a single case (2009:50). Other authors have echoed this last concern, and have also suggested that the empirical grounding may be less convincing than when multiple cases are used (Eisenhardt & Graebner, 2007).

However, in their defence of the single-case approach, Dyer & Wilkins (1991) argue that a multiple-case design can result in different constraints, with descriptions being at risk of superficiality, thus missing the deeper social dynamics associated with a single-case design. There are also concerns relating to the volume of data that may be generated in a multiple-case approach, which has implications for resources, especially the time taken to collect and analyse data generated (Yin 2009:53; Dyer & Wilkins, 1991).

Because there seemed to be quite a debate in this area, I did not feel that the single case focus emerging during this time was necessarily detrimental to the research design. Of course, I had been able to observe several events and study days in cases two and three before access became problematic, and was able to feed my observations into the fieldwork for case one. Figure 4.3, later in the chapter, shows the cases involved, with case one at the centre and other cases as satellites. The diagram shows the degree of access

achieved, and it is immediately apparent that case one offered complete access throughout, from planning of the programme to the final 'celebration' day when delegates completed the programme.

During the course of observing case one, I began to consider which of the delegates might go on to become participants in the interview section of the study, and this phase is detailed in the next section.

4.4.3 The interviewees

In this element of the study, purposeful sampling was applied. Morse (1991:129, cited in Coyne, 1997) has described a clear process in purposeful sampling, and this relates closely to how I undertook the selection of interviewees:

- Initial interviews are with participants who have a broad knowledge of the topic, or who might be considered 'typical' in some way;
- As the study progresses, description is expanded with more specific information, and so participants with this particular knowledge are sought out deliberately;
- Finally, the researcher looks for informants who have atypical experiences, so that there is a range of experiences explored, and thus the breadth of the phenomenon may be understood.

During the course of case one, which ran over a period of six months, I was able to establish rapport with many of the 30 participants. At the beginning of the programme, I had given a presentation to the cohort, in order to introduce myself and explain the research study, and many of the delegates showed significant interest in what I was doing. Gradually, I identified individuals whom I believed would be able to provide interesting insights into the experience of midwifery leadership, both in terms of its development and its enactment.

Once the first few interviews had been completed, I noticed some homogeneity among the interviewees, in that they had all been nurses prior to becoming midwives. I wanted to include midwives who had come into the profession directly, in order to explore their career journeys, and so sought out individuals from the programme whom I knew to have taken the direct entry pathway. This automatically added breadth to the data, as these interviewees had necessarily been in the profession for a shorter time, given that direct entry midwifery is a relatively new direction. It also provided a different perspective on career journeys, adding the 'atypicality' suggested by Morse. **Appendix 2** gives details of the nine interviewees, showing the breadth of their experiences in the NHS.

The interviews provided rich and detailed data, including descriptions of the participants' individual leadership journeys, much discussion on the subject of the enactment of leadership, and an emphasis on their retaining the 'midwife' identity even when no longer working in the clinical setting. Further details of these findings will be provided in later chapters, but the reason for mentioning the centrality of a continued 'midwife' identity here relates to the next section, involving selection of an online forum for further exploration of the question of identity.

4.4.4 The online sample

As a former clinician, and during discussions of the research findings with former colleagues, I became aware that the positive narrative around identity emerging from the interviewees was perhaps not matched by the perception of clinically-based staff. More details of this theme are provided in chapter seven, but for now I will just say that a possible counter-narrative was evident, and I was keen to explore this idea.

I had hoped to interview clinical-level midwives as part of case three, but access problems meant this would not be a realistic possibility. Instead, I made the decision to use an

alternative method of data collection, in the form of online midwifery forums. Details of the process and challenges associated with online research are presented later, but this section of the chapter deals simply with the selection of a sample.

A search was undertaken, using the terms 'midwifery forum UK' and 'midwives forum UK'. This search brought up The Midwifery Forum, as well as several aimed at student midwives and nurses. The RCM forum was then identified through my own membership of the RCM, and I was directed to The Midwifery Sanctuary by a former colleague.

These three forums were then examined for their appropriateness for the current part of the study. **Appendix 3** gives further details of their characteristics.

The Midwifery Forum, while active several years ago, now appeared to be somewhat less well populated. For example, only 17 topics had been posted in the 'chat' facility over the year prior to Spring 2012, when I was exploring this area, and the majority of these had had little or no response.

The RCM Communities forum was a relatively recent innovation, having been created in October 2010 with the aim of encouraging collaboration and discussion within the various groups of midwifery staff. However, membership of groups was relatively small (for example, the 'midwives' group had 454 members), and new threads, which were usually started by RCM administrators, struggled to gain comments from group members. The Midwifery Sanctuary, however, appeared well populated and thriving in its discussions. Users posted on a wide variety of topics, both relating to midwifery and non-midwifery elements of participants' lives, and new threads generally received a good number of responses.

Having looked closely at all three sites, and having done a brief search of the terms 'managers' and 'management' on each, I decided to concentrate on The Midwifery

Sanctuary, as this turned up a large number of comments posted by users. I did, however, register with all three forums, as I was interested in seeing more of what was posted, even if I decided to interact with just one.

4.5 Research Design

4.5.1 Final study design

As so often happens in research studies, the process of design was evolutionary and developed over a long period of time. Problems with access were the principal concern during this phase, but finally a design was formalised. Figure 4.3, below, shows the cases involved, clearly identifying that complete access was gained in case 1.

Fig. 4.3 The cases

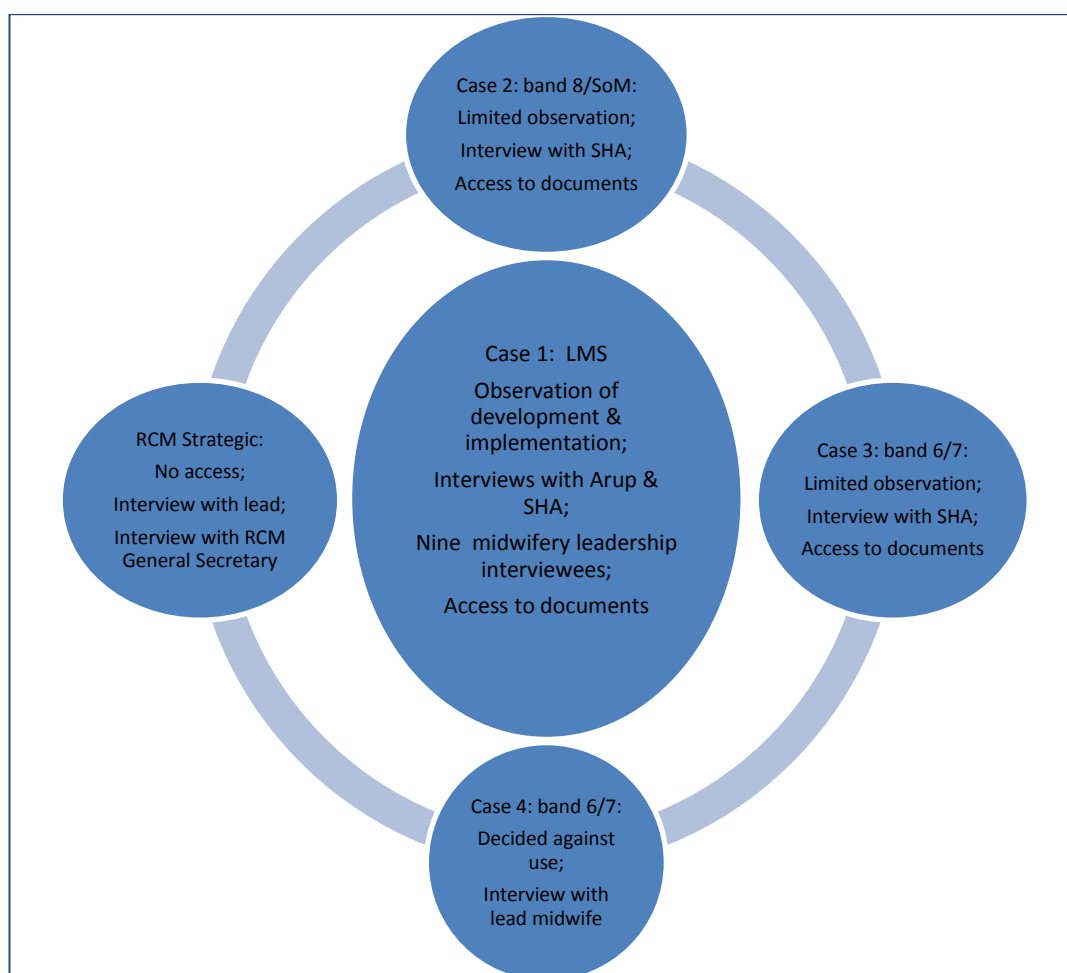
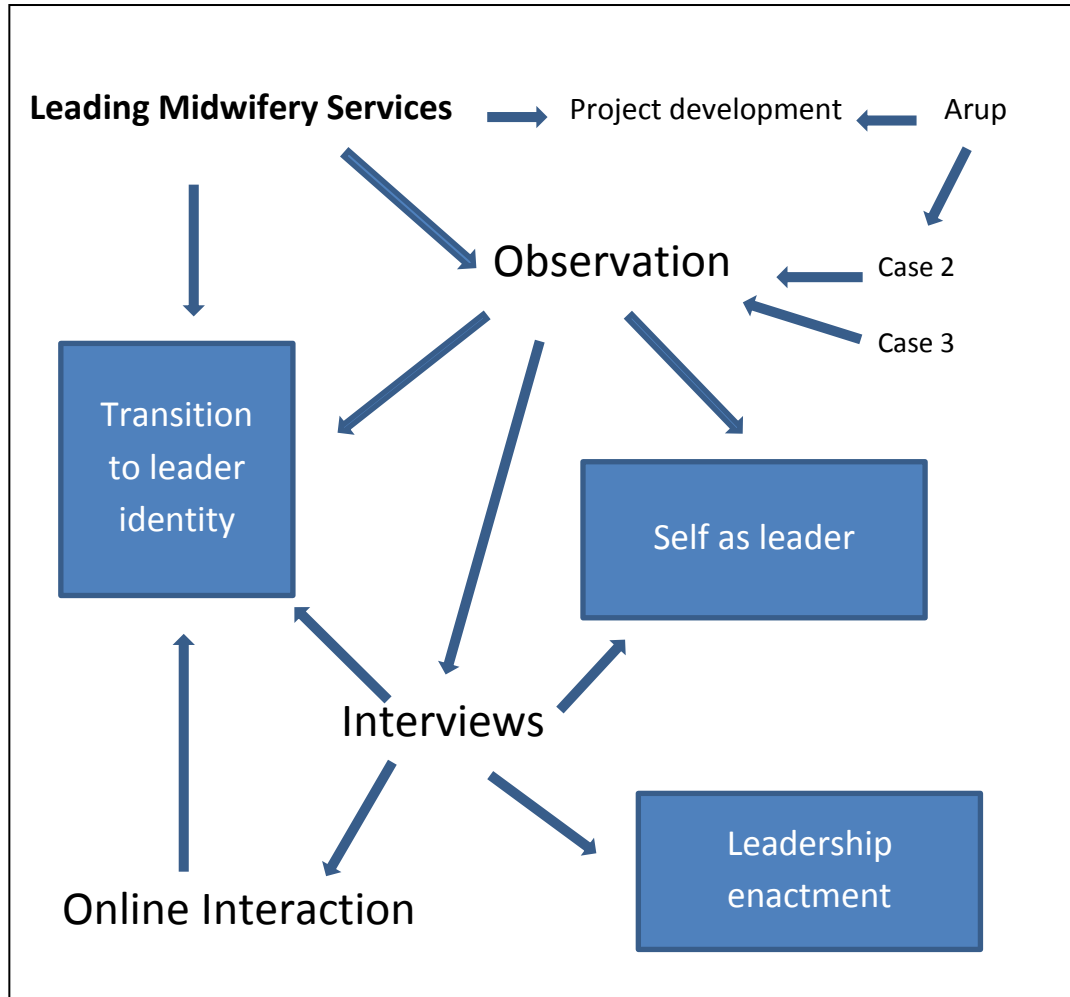


Figure 4.4, below, shows the path undertaken through study design, with the interplay between research questions and empirical work demonstrated clearly in its complexities.

Fig 4.4 Research Design



4.5.2 The central case

The programme was initially called ‘Aspiring Heads of Midwifery’, but this was altered to ‘Leading Midwifery Services’ when the point was raised that many of the delegates would in fact already be heads of midwifery. The programme was aimed at various positions in senior midwifery – heads of midwifery, matrons, supervisors of midwifery, and senior educationalists – and its purpose was to help these midwives see what their individual leadership journey might look like, and to give them access to the ‘bigger picture’ of NHS

leadership, above and beyond midwifery. At an organisational level, the programme aimed to confront the issue of succession planning. It had been identified that a significant number of heads of midwifery were approaching retirement, and that there were insufficient numbers of midwives adequately equipped or willing to replace them. Anecdotally, according to one of the programme designers, the Head of Midwifery role had been described as grossly unattractive, almost a poisoned chalice, by senior band 7 midwives. By the end of the programme, the SHA aimed to be 'spoilt for choice' in midwifery leadership, with delegates ready and willing to approach the head of midwifery positions when they became vacant. Within the programme design, there was a clear echo of the Next Stage Review (DH, 2008), which talked of the importance of developing clinicians into leadership roles, and Maternity Matters (DH, 2007), with its emphasis on the importance of strong and effective midwifery leadership for the development of a model of midwifery-led, woman-centred care.

The aim was that delegates would nominate themselves for the programme, because as the Arup programme designers commented, this might identify so-called 'invisible talent'. After discussions between Arup, the SHA representatives, and three senior midwives involved in the planning and design of the programme, it was decided that access would be through a combination of self-nomination, development centre, and manager support, with conversations between Arup and line managers as necessary.

This was an issue that generated some debate at the design phase, as Arup were very keen for potential delegates to nominate themselves. This drew the comment from one of the senior midwives that she believed they should have final say on whether delegates were suitable for the programme, as 'we wouldn't want any undesirables'. One of the SHA representatives countered this with, 'Yes, but if you do what you've always done, you'll get what you've always got'.

The programme designers recognised that with a relatively large pool of delegates, they would need to cater for a variety of development needs. It was expected that some midwives would have leadership experience at purely operational level, while others would have experience at strategic level, and all would have had varying experiences of past leadership development. For this reason, two programme pathways were devised:

- Path A: a more formal learning structure, a 'building blocks' of leadership. It consisted of two two-day residential modules, three master classes, four action learning sets, and stretch assignments;
- Path B: largely characterised by self-directed 'on the job' learning, a more personalised programme. An initial one-to-one coaching and personal development planning session led to stretch assignments. These delegates also attended the master classes and action learning sets, but not the residential modules, and were given 6 one-to-one coaching sessions.

The thirty delegates met for the first time in April 2010 at a launch event, and a month later attended the development centre, following which they were assigned to the appropriate pathway.

The programme ran from June until December 2010, and had its official end with a celebratory event in January 2011.

4.5.3 Summary

In describing in detail the study design, I have been explicit about the organic and pragmatic nature of the selection of cases. I have addressed issues of sampling methods and concerns about numbers of cases, but have also described how a single central case can be valuable in its own right. I was able to gain complete access to case 1 (LMS), which offered me the chance of an in-depth exploration, and I also had the benefit of partial

access to three other cases and input from a number of knowledgeable individuals at strategic level.

I now turn to the specific methods used to generate rich, holistic data for the study, offering a justification for the selected methods and examining benefits and potential pitfalls for each.

4.6 Research Methods

4.6.1 Overview

This section of the chapter deals with the specific methods used to gather data in support of the research questions. I adopted a triangulated approach, for two reasons; first, in order to attain an in-depth understanding of the phenomenon, and second, to reduce the likelihood of misinterpretation (Tobin & Begley, 2004). I address each of the data gathering methods in turn, describing the rationale for their use as well as potential strengths and weaknesses, and I give details of the methods within the context of midwifery leadership development programmes.

4.6.2 Observation

The rationale for using observational methods is based on the principle of gathering information in a naturally-occurring situation (Burns & Grove, 1999:358), and of eliciting ‘nuances of incidents and relationships’ in the lived experience of participants (Simons, 2009:62), reflective of the belief that behaviour is expressive of deeper values and beliefs (Marshall & Rossman, 1999:107).

A clear rationale for the use of observation in case study research is offered by Simons (2009:55), and this was followed in the process of study design:

- Observation can help to gain a comprehensive picture of a situation;

- Observation offers the potential for rich description, which can form the basis for further analysis and interpretation;
- Observation is a way of discovering the norms and values that are part of a culture or subculture;
- Observation provides a method for cross-checking interview data.

I was keen to use observational methods at the leadership programmes within this study, for several reasons. First, as part of the process of gaining the holistic view I was aiming to achieve; second, in order to help understand midwifery beyond my own experience of the profession; third, in order to inform future interviews; and finally, in order to gain rich detail about contemporary midwifery leadership programmes in the context of contemporary NHS policy.

As with all research methods, there are strengths and limitations associated with the use of observation in a study. Strengths tend to relate to the 'real world' perspective of observation. There is a perceived lack of artificiality, and the ability to simply watch and listen, rather than having to elicit responses from individuals (Robson, 2002:310-11). I certainly found this to be the case during observational work, and was able to gather several significant themes which were subsequently used in the interviews.

Limitations associated with observational study lie within two areas; first, the heavy investment of time and effort involved, as effective observational work requires long periods in the field (Robson, 2002:310). However, I had the luxury of time, and the observation periods fitted easily into my schedule.

The second challenge in observational studies relates to how the researcher interacts with the field; that is, decisions must be made about how much interaction and participation is required. The principal concern here relates to risk: if an observer remains detached, there

is the risk of a negative or unwelcoming response from participants, but if the observer becomes involved in the field, there is the risk of compromising the researcher role (Robson, 2002:311).

The researcher role is a central concern in observational work, but is not necessarily a fixed element, with the idea that fluctuations can occur between degrees of researcher involvement in the lifetime of a study (Adler & Adler, 1987:42). The question of involvement is clearly linked to the issue of participant versus non-participant observation. A distinction is made by Burns & Grove (1999:358) on this subject:

- The participant observer will take part in a situation under study, rather than simply acting as 'researcher';
- The non-participant observer does not take part in the situation under study, but may well be present in the environment.

However, the reality of participant versus non-participant observation is blurred, and I found this a complex area of the study. Generally, literature suggests the necessity of compromise, as no researcher in the field can ever be truly non-participant, or indeed a full participant (Atkinson & Hammersley, 2000; Flick, 2002:142). For my part, this was a central issue in the observational part of the study. As a former midwife (and in the eyes of many of the leadership development programme (LDP) delegates, *still* a midwife), I was welcomed into the study environment by all the participants I met. I was not entirely comfortable with this, and it exposed a dichotomy in my identity as researcher: to the midwives attending the leadership programmes, I appeared as 'one of us', as I spoke the same language, and had in fact worked in the same hospitals as several of them. This was true of cases one, two and three, and our shared history and experiences were the basis for many conversations.

However, I was unsure whether I really was 'one of us' in the midwifery context. I was attending leadership programme events as a researcher, situated within a business school environment. I was necessarily observing interactions and events during the fieldwork, and this at times gave me the sense of being somehow duplicitous (de Laine, 2000:113). And apart from the delegates encouraging me to join them in round table discussions, the programme facilitators also seemed keen to include me in activities. I realised early on that a simple non-participant or participant decision was over-simplifying my role, and gradually became comfortable with a dual position.

The issue of my role was apparent in relation to issues of access to leadership programmes, as described earlier. Gerson & Horowitz (2002:207) write that there are a number of factors impacting on the likelihood of gaining access to the field. These include the type of setting, the degree of control exercised by participants, and the perceived social distance between participants and researcher. Interestingly, the delegates, as described above, were universally welcoming of my presence, and it was the SHA for cases two and three that made access problematic. Here, the power of the gatekeeper was evident. While the Arup consultants were supportive of my case for access, the SHA gatekeeper made the final decision with regard to payment for my presence, which was unviable.

Within case one, access was granted to all areas of the programme, from planning through to completion. Access was certainly made easier by the fact that my non-academic supervisor was involved throughout the programme development, and also by the fact that the Arup consultants were welcoming and supportive. The one area where negotiation was required was during the action learning sets which formed part of the programme. Here, I negotiated with the group's facilitator, and made sure that all delegates (a small group of around six) were comfortable with my presence on each occasion. Similarly, I

always asked the Arup consultants to make sure delegates were happy with my presence during large group teaching and interactive sessions, before I entered the room.

The next decision lay within whether to apply a structured or unstructured observation approach, and again I took a position of compromise. Unstructured observation has been described in relation to a lack of pre-determined categories or classifications, with observations made in a more natural, open-ended way. Here, behaviour is observed as actions and events as they naturally unfold, with categories and concepts used to describe and analyse data emerging later (Punch, 2005:185). In relation to case study research, unstructured observations are most often used to document an incident or event, explain the culture of an organisation, or provide the basis for interpretation of data obtained through other means Simons (2009:56).

The contrast with structured observations is clear. Here, observations are reductionist, based on pre-determined categories, with behaviour broken down into small parts. The risk is that a view of the 'big picture' may be lost, although according to Punch (2005:186), recording and analysing of data is easier and more standardised.

As an observer of midwifery leadership development programmes, I adopted an unstructured observational approach, in the sense that I did not use a standardised schedule. However, I did take a systematic approach (Robson, 2002:325), being aware that if I did not remain mindful of the rationale for my observation role, I risked becoming completely immersed in the setting.

In the cases I observed, I initially adopted Marshall & Rossman's 'broad area' approach (1999:107), entering the field with a focus on establishing what midwifery leadership development looked like to those delegates attending the programmes. I addressed the issue of 'insider-outsider' by being careful in my field notes. Rather than writing potentially

sensitive observations at the time they occurred, I tended to wait until it was time to leave the scene and then immediately wrote a narrative of the day's events. My field notes would often include one-off sentences, which would then be expanded upon in the research diary. The 're-storying' of observations is described in greater detail, and in the context of other elements of the research methods, in the data analysis section of this chapter.

4.6.3 Interviews

I used in-depth, loosely structured interviews, which have been described as the 'gold standard' of qualitative research (Silverman, 2005:291; Rapley, 2007:15), applying Mason's connection between interviews and a social constructionist perspective (2002:225), specifically her suggestion that the roots of the qualitative interview lie in traditions giving privilege to the accounts of social actors. She continues,

"Interview methodology begins from the assumption that it is possible to investigate elements of the social by asking people to talk, and to gather or construct knowledge by listening to and interpreting what they say and how they say it".

In this study, the interviews were used to explore career narratives of midwifery service leaders, in the context of the research questions, and to address general themes of midwifery leadership and its development, particularly in the context of the programmes the interviewees had recently completed. The first six participants were interviewed twice, with a further three interviewees added after the first round. This second group of participants was interviewed once each. The first interviews were carried out around four to six months after the completion of the leadership development programme, and **Appendix 4** shows the interview guide for these first meetings. The second (subsequent)

interviews took place several months after the first round. Table 4.1, below, shows the schedule and timescale of all the interviews.

Table 4.1 Interview schedule

Pseudonym	Role	Interview schedule	Interview schedule
		1	2
Deborah	Senior matron	March 2011	August 2011
Lesley	Matron	April 2011	September 2011
Natalie	Lead midwife for education	April 2011	October 2011
Pauline	Matron	May 2011	November 2011
Louise	Matron (acting)	May 2011	September 2011
Heather	Matron	May 2011	September 2011
Caroline	Practice development matron		September 2011
Karen	Matron		October 2011
Susan	LSA midwifery officer		November 2011

The site of interviews was considered important (Rapley, 2007:18), and careful decisions were made with regard to this issue. All the respondents were in management or leadership positions, and as such had full diaries, which meant that some negotiation was necessary to secure appropriate amounts of time for interviews (interviews lasted usually more than one hour). Following discussion, all the participants decided to be interviewed in their workplace. While this meant there was a risk of interruptions and conflicting demands on their time, it also allowed me the opportunity to pick up cues that would later find their way into the data; for example, we had conversations about the challenges of having an office within or beyond the clinical area, and about the value of wearing uniform or civilian clothes, based on what I observed in the interviewees' workplace.

All interviews were tape recorded with participants' consent, which allowed for ease of interaction throughout, and gave me the ability to replay interviews afterwards (Rapley, 2007:18).

A loosely-structured approach to the interviews was taken, in order to allow the respondents to shape the encounter to a significant degree, and to allow for flexibility (Mason, 2002:231). As demonstrated in the interview guides, the aim was to examine themes emerging from observational data, wider themes in the midwifery leadership narrative, and the individual leadership journeys of participants.

The importance of the personal narrative has been described by Lawler (2002:242):

“Stories circulate culturally, providing a means of making sense of that world, and also providing the materials with which people construct personal narratives as a means of constructing personal identities”.

The explicit 'story-telling' element of the interviews was central to the study, and in the interviews this was the part where there was little conversational emphasis – I aimed to have the participants relate their leadership stories as they recalled them, and I interjected only to clarify, for example, dates of particular events. A central challenge of narrative interviews involves guiding respondents through “a maze of life experiences in an orderly fashion and within a limited period of time” (Gerson & Horowitz, 2002:204), and at times I did need to bring stories back into focus, as respondents talked enthusiastically and at length.

More generally, interviews proceeded in a highly conversational manner (Mason, 2002:225). I believe this was for three reasons: first, being regarded as 'one of us' meant that interviewees behaved towards me in a conspiratorial manner at times, especially when speaking about common ground such as locations where we had worked; second, we had

been in close contact throughout the leadership development programme, and so stories were told *between* us, rather than just by the interviewees; and third, in the later interviews, I was exploring emerging themes with the respondents, and so there was necessarily a conversational tone to the encounter. These elements echo the idea that interviews, by their very nature, are social encounters, through which speakers work collaboratively to produce accounts and versions of experiences, feelings and opinions (Rapley, 2007:16). As such, it is the conduct of *both* speakers that defines the success of an interview encounter, with the combined efforts of interviewee and interviewer resulting in a co-production (Mason, 2002:227).

Interviews elicited rich data, with participants giving full and interesting answers to all questions. By the ninth interview, no new themes were emerging, and in fact the experiences and opinions of all nine participants contained extremely strong common themes. I decided at this point that theoretical saturation had been reached (Gerson & Horowitz, 2002:211), and discontinued this element of the study.

4.6.4 Online interaction

The third element of the study was undertaken in March and April 2012, following analysis of data from observations and interviews. This section of the chapter deals with issues around data collection via the Internet, and describes the process undertaken.

Internet mediated research poses a number of dilemmas. These can be summarised neatly:

- What constitutes 'privacy' in an online environment?
- How easy is it to gain informed consent from participants, and what does informed consent actually mean in such a context?
- Can anonymity be a certainty when disseminating findings?

- How is a researcher to ascertain the ‘real’ identity of participants?

These four issues were of central concern during this phase of the study, and are addressed here, as I outline the way in which the internet research was undertaken.

Ethical concerns have long troubled researchers working with data gained through online interaction (Ess, 2002), part of the problem relating to the fact that different online methods will produce different research relationships. Therefore, ethics may vary with methodology and context (Bailey, 2001). In my case, being a novice in the world of internet research, I decided to try to apply the same ethical principles that had guided the ‘real’ world part of the study. Namely, ensuring an honest and transparent approach, and including attention to the principles of informed consent, anonymity, and right to withdraw. As the British Psychological Society suggest in their internet research guidelines, such work

“...requires the application of the same controls, checks and balances that apply to good research in traditional settings. It should also involve the same ethical considerations being given to people who are taking part in the research, whether they are simply being observed or are invited to actively engage in experimental tasks or activities” (BPS, 2007:1).

The issue of privacy has been suggested as the most important ethical issue for internet researchers (Thurlow *et al*, 2004), for the simple reason that there is a lack of clarity as to what entails public or private space on the worldwide web. According to Hewson *et al* (2003), data that have been made voluntarily and deliberately available in this domain should be accessible to researchers, as long as anonymity is ensured. However, even this view has been challenged, with suggestions that an individual’s understanding of privacy

might be determined by who they believe sees the work, and what purpose they attach to it.

On The Midwifery Sanctuary site, basic access is public, given that all posts (other than those within the 'members only' area) are visible without any need to register or log in. The search facility is also public. I began my work by searching through the site for information about whether I would be able to use my findings in a thesis, and what permissions might be needed to do so. I could find nothing relating to privacy issues within any of the various forums, including the 'welcome' board and the 'frequently asked questions' thread. I later posted a question relating to use of findings, but there appeared no clear policy or guidance in place. In the meantime, several of the respondents individually noted their consent for me to use comments they made, and nobody at the forum suggested that it might not be appropriate to do so.

I was keen to begin by searching the site for the terms 'managers' and 'management', in order to get an idea of whether such topics came up in discussions or debates, and so needed to make a decision as to whether to become a registered user of the site. This raised the issue of whether 'lurking' is an acceptable part of internet mediated research.

In their guidelines, the British Psychological Society suggest 'lurking' as the most likely instance of deception in internet research (BPS, 2007:4). However, Chen *et al* (2004) have suggested that such activity might help the researcher to gain an understanding of important topics or the culture of a group, although these authors found lurking was generally disapproved of as a data collection method. Similarly, Eysenbach & Till (2001) write that there is a risk of individuals 'lurking' in online communities being perceived as intruders.

Based on these findings, and knowing that I was likely to want to post questions on message boards as part of the work, I decided to register with the site prior to undertaking any further study. Having completed the relevant online form, I then had to wait for a moderator to approve my registration, which took about a week. Once registered, I was able to log in, and also gained access to the 'members only' area of the site.

Having spent some time looking through various areas of the Sanctuary, and getting a feel for what kinds of conversations and interactions were going on, I decided to do two things. Firstly, I posted a message introducing myself, to include information about why I might be asking questions. I used informal language:

"Hello, this is exciting! I'm a former midwife, but I left practice two years ago to do a funded, full-time, three year PhD. Yes, I know – I feel very, very lucky! My thesis is about midwifery leadership – how clinical leaders got there, and how we might narrow the chasm that sometimes appears between clinicians and leaders/managers. And most importantly, how we can encourage more midwives to be helped appropriately into future leadership positions. I'm a bit passionate on this subject, and I'm keen to see whether my ideas resonate with midwives out there, so I'd like to ask questions periodically that I can hopefully use in the thesis".

Within this post, I was attempting to address the issue of consent, which is another area of concern in internet mediated research, and closely linked to that of private/public space. Once again, there appears to be no consensus on the subject, with guidelines generally considering an approach close to that used in 'real' world research to be the most appropriate. Obviously, with over 3000 potential participants reading this post and going on to view any questions I would pose, this was a matter for some thought, and gaining written consent would be impossible. I was guided by the idea that I should be as open and honest as possible, and the introductory post was designed to fulfil this aim. I considered

who might respond to my posts, based on what I had already seen on the site. There was a sense of a lively community here, and I gained the impression that people felt safe to post on a vast range of subjects, both within and beyond midwifery.

One thing that I noticed was that some members obviously knew others, apparent in some of their exchanges and conversations, and despite pseudonyms being applied throughout the site (I became '30fairy'). This brings me to the subject of anonymity, which has been identified as the third consideration in this mode of research.

Questions of pseudonyms are complex in internet research, with the BPS guidelines (2007:4) suggesting the importance of treating individuals posting to forums with the same ethical consideration as for 'real life' research. This relates to the fact that when quoting responses, participants might be traceable through internet search engines. However, the other side of this argument comes back to the idea of public space, and to what degree online posters understand their comments and conversations to be taking place in a public arena. The Midwifery Sanctuary allows users to give as much or as little information about their identity as they wish. Table 4.2, below, gives details of how I identified myself at the online forum, using the registration form:

Table 4.2 Online identification

	My details	Notes
Username	30fairy	Pseudonyms used across the site
Rank	Weeing on a stick	A midwifery joke by the site, relates to how many posts you have written
Occupation	Doctoral student, 3 rd year, scared of writing up	Often left blank, sometimes professional occupation given, e.g. midwife, student midwife
Location	I left this blank	Often left blank, sometimes general geographical location given
Interests	Oh, where to start...	General information, often left blank

Groups	Registered users	Can also include e.g. moderator, administrator
Status	Always learning	Often left blank, sometimes 'midwife', sometimes personal

Most site users appeared to give very little information, and often the only identifying elements were their username and rank. While this appeared to answer my concerns about identifiability of participants at the point of posting, the issue of whether to add a second layer of disguise (beyond their site pseudonym) was one that required much thought. Based on the BPS guidance, I eventually presented findings without any direct identification, instead referring to which question the comment related.

By now, I was clearly not 'lurking', and I decided that my second action would comprise two parts. First, I undertook a search of the site, using the terms 'managers' and 'management'. Both these searches returned a large number of results, and I decided to limit the search to one year back. A further complication was in the use of the word 'management', as in midwifery this relates to various clinical elements, such as management of the 3rd stage of labour, or management of induction. However, I sorted through the results to identify those relating to the type of management I referred to.

Having undertaken the search, and having gained an idea of the kinds of references midwives on the site made to managers and management, I commenced the second part of my data collection, which involved asking specific questions via one of the subject areas. I based my questions in the 'midwifery' part of the site, on the basis that it seemed an appropriate place in which to pose such questions, and also because this area is particularly well populated and new threads seem to generate a good amount of discussion and feedback.

Questions were based on four elements of the study that had been explored already:

- Observation of midwifery leadership development programmes;
- The midwifery matrons/heads of midwifery/educationalist interview findings;
- The wider literature around NHS management and leadership;
- The results of the Midwifery Sanctuary searches of ‘managers’ and ‘management’.

In total, I asked four questions on the subject of midwifery leadership and management, over a period of five weeks, which are detailed in table 4.3 below.

Table 4.3 Questions asked via the Midwifery Sanctuary

Date	Question
10 th March: Midwifery Managers	Hi, I have a question that I need help with... I’m a PhD student and former midwife, looking at midwifery leadership, and I’d love to hear fellow midwives’ thoughts on this: Can you call yourself a midwife if you don’t work clinically?
21 st March: Hands up, Midwives!	Hands up if you aspire to become a midwifery manager. For example, are you aiming for a ward manager post, or would you like to become a matron or even a head of midwifery one day? And if not, why not?
30 th March: Matrons: what are they?	So, in my PhD thesis, I’ve been talking to matrons, who have very clear ideas about what their identity is. But I’d like to know what you think: when I say ‘matron’, is your first response ‘midwife’, ‘manager’, or ‘leader’? Or maybe a combination of all three? A thousand thanks for all the responses so far to my other questions – your opinions are super valuable!
16 th April: Matrons (again, sorry!). Later, changed to Beautiful Midwifery Leadership!	So, as I’m sure you know by now, if you’ve seen my other questions, I’m looking at midwifery leadership for my PhD. The responses I’ve had have been great, and as a former midwife myself, I can relate to much of what is being said. I have one more question, and as

	<p>ever, I'll be hugely appreciative of your responses: What can midwifery managers (at all levels of the service) do to earn the respect of midwives? Can you think of anything that would make their role seem more attractive for your own career path? I know, that was two questions – my apologies!</p>
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Again, I was careful to pose the questions using language and style that I felt was appropriate for the site, and I was particularly mindful of the potential impact of an engaging title. Table 4.4 below shows the response rate for the four main questions, as well as for the introductory post, as of April 18th, 2012. By this date, I was seeing no new responses to the questions I had posted, and so decided to end this element of the data collection.

Table 4.4 responses to questions on the Midwifery Sanctuary

	Views	Responses	Site area	Date of question
Question 1: Midwifery Managers	698	22	Midwifery	10/3/12
Question 2: Hands up, midwives	691	25	Midwifery	21/3/12
Question 3: Matrons: what are they?	393	11	Midwifery	30/3/12
Question 4: Beautiful Midwifery Leadership	260	9	Midwifery	16/4/12
Introduction	196	5	Welcome to the forum	10/3/12

4.7 Data Analysis

4.7.1 Overview

Denscombe (2007:248-50) describes a number of principles associated with the analysis of qualitative data:

- It generally involves observational, reporting or recording information, and is thus concerned with the written word rather than numbers;
- Thick description is used, involving detailed descriptions of people and events, being considered necessary to convey the complexity of a situation;
- Research tends to be small scale, due to the use of textual data and thick description;
- Analysis of the data is concerned with contextualising, seeing relationships and interdependencies rather than attempting to isolate variables or focus on specific factors;
- There is emphasis on the role of the researcher in data construction, where the researcher's 'self' has significant bearing on the nature of the data collected, and its interpretation.

I applied the principle of a holistic view of data analysis to all elements of the data gathered (Lincoln & Guba, 1985:39), using Denscombe's themes as a guide. The following three data chapters will demonstrate the application of a 'thick description' approach to analysis, as well exploring the relationships and interdependencies between themes that emerged. I have explicitly described my role as researcher in the study, and this will be explored further in relation to reflexivity later in this chapter.

4.7.2 Data management

Data analysis began in the field, during the period spent gathering data, as I identified problems and concepts which might help in understanding the subject of midwifery leadership identity transition (Schutt, 2012:325). Observational data informed interviews, and both elements informed the online phase of the research.

Data management was undertaken as follows:

- Observations: reflective accounts written after observation periods, using a ‘whole’ day approach, and narrative built. Themes used to inform interviews;
- Interviews: transcribed by myself, notes made during transcription as themes emerged. Second interviews to examine emergent themes and to check interpretation with interviewees.
- Online interaction: following analysis of LMS interviewees’ identity narratives and observations – development of themes, a type of member checking and emergence of counter-narratives.

All transcripts, observations, notes from online interaction and the research journal were stored in a locked cabinet within a locked room. Back-ups were made of all material, whether it be digital or photocopies.

4.7.3 Transcription

All interview data were transcribed by myself, for three reasons: first, the expense of hiring a transcriber was prohibitive; second, I was keen to remain close to the data, as interviews were lengthy and I wanted to be able to replay the interaction as it had happened; and third, commencement of analysis at the transcription stage would inform later interviews, through the expansion, clarification or re-formulating of questions as necessary (Riessman, 1993:2).

4.7.4 Process of analysis

Schutt (2012:325) gives a clear description of the stages of qualitative data analysis:

- It begins with the documentation of data and the process of data collection, described as “keeping track”;
- The organisation and categorisation of data into concepts;
- The connecting of data to show how one concept may influence another;
- Corroboration and legitimisation, through the evaluation of alternative explanations, disconfirming evidence, and the search for negative cases;
- The representation of the account, through reporting findings.

As general principles, these suggestions were adopted for the analysis of data from the study. However, the holistic approach I took to the interview transcripts, through the application of a narrative analysis perspective, found its way into the observational data.

Appendix 5 shows how this approach worked in practice. The data here is from an observation day at case two, and while descriptive in nature, I was writing the narrative as both analysis and reflection. Themes emerging from a day such as this included ‘pride in development’ and ‘lack of talent management awareness’ both of which issues appeared in the later interviews.

Distinctions have been made within the field of narrative analysis, where “analysis of narratives” involves using paradigm thinking to create descriptions of themes that hold across narratives, and “narrative analysis” involves collecting descriptions of events and happenings, and then configuring them into a story using a plot line (Polkinghorne, 1995:12). I applied both approaches to the analysis of study data. While I was keen to retain the essence of individual leadership journeys, I was also aware of the need to answer the second research question concerning midwives’ needs in relation to leadership development, and realised that coding and categorising of themes emerging from the various data sources would enable this.

Clandinin & Connelly (cited in Creswell, 2013) suggest a “re-storying” approach in narrative analysis. Such a framework is created by gathering stories, analysing them for key elements such as time, place, plot and scene, and then re-writing the stories to foreground the chronology of the account. Again, I applied this technique in the analysis of interview data. **Appendix 6** is ‘Heather’s story’, where the chronology of her account has been re-storied after the analysis, and appears alongside significant themes emerging from the interview.

Findings from the online element of the study were coded according the relevant question to which the data related. Again, a re-storying approach was adopted using the emergent themes, which acted as a strong counter-narrative to that produced by midwifery leaders in the interview section of the study. **Appendix 7** shows the process of translating themes into an overarching narrative from the online interaction, and is contrasted with a narrative associated with the midwifery leaders’ narratives on the same subject.

Alongside the strongly narrative-focused analysis, a coding and categorising approach was also employed. I considered this necessary, in order to gain some mastery over the sheer volume of the data (Seers, 2012). I considered the use of computer assisted software, and got as far as entering the first six interviews onto NVivo, but ultimately felt more comfortable with pen and paper. This was a personal decision, and related to the fact that I felt I could achieve the same depth of analysis using pen, paper, colour coded markers, and margins (Fielding, 2002:162). All the interviews were coded in the same way, with themes identified over the period in which the interviews were undertaken, and beyond. **Appendix 8** shows this process, with an example of emergent themes and the associated representative quotes.

More detail of the study’s findings will be provided over the following three chapters.

4.8 Ethical Considerations

Ethical issues may arise at any stage of a research study (Bloomberg & Volpe, 2008), particularly during data collection, interpretation, and dissemination of findings. This study involved NHS professionals, and as such was subjected to a rigorous process in order to gain approval. Ethical approval was gained through the University of Nottingham initially, and then by the University of Warwick when my studies moved there, and through the Proportionate Review Sub-committee of the NRES Committee East Midlands. This was a lengthy process, and shortly after gaining ethical approval via NRES, it was decided by NIHR Clinical Research Network that NHS approval was not necessary for the study. However, the principles of informed consent, right to anonymity, and right to withdraw were followed throughout.

4.8.1 Informed consent

Informed consent was considered of crucial importance throughout the study. With various methods employed, informed consent was dealt with in several ways:

- During the observation phase: I gave an initial presentation to the case cohort at the outset of the development programme, in order to explain the study I was undertaking, and to give delegates the opportunity to decide they were not comfortable with my presence. At the beginning of each study day, the Arup facilitator would invite me into the room only when delegates had been informed that they did not need to consent to my presence. In the action learning sets, where potentially sensitive subjects were being discussed, I again informed delegates that they were free to refuse me entry. At no time did I encounter any objection to my presence.

- During the interview phase: potential interviewees were approached informally during study days, and the possibility of an interview was discussed. All the delegates I approached expressed a desire to take part in the study. I then sent an email, containing a participant information sheet, and asked the potential interviewee to read it thoroughly before agreeing to meet with me. When the interview commenced, I checked for any misunderstanding of the purpose of the interview, and all participants were asked to read and sign a consent form. They were made aware that they could withdraw from the interview process at any time.
- During the online interaction: I made my reason for asking questions clear throughout the process, identifying myself as a PhD student, and explaining exactly what the purpose of the questions was, and how data might be used.

4.8.2 Confidentiality and anonymity

Again, this issue was dealt with according to the data collection element:

- During the observation phase: Data from the observation sessions were not made attributable to any individual attending as a delegate.
- During the interview phase: data were securely stored, in a locked cabinet within a locked room. All interview transcripts were anonymised, with pseudonyms applied to interviewees. Data identifying location were removed from transcripts.
- During the online interaction: pseudonyms are used on the website, but direct quotes were further anonymised by removal of pseudonyms.

4.8.3 Data protection

Coded interview transcripts and information about participants were stored on password-protected computers, which could only be accessed by the researcher. Consent forms

were stored in a locked cabinet within a locked room, and will be destroyed according to the University of Warwick's guidelines.

4.9 Rigour in Qualitative Research

4.9.1 The interpretivist approach

Issues of validity, reliability and generalisability are contested in the interpretivist paradigm. The basis for this challenge lies in the idea that language is at the root of the articulation and communication of philosophical beliefs (Tobin & Begley, 2004). From this perspective, because language differs between philosophical perspectives, the transference of terms across paradigms is not appropriate due to inconsistencies between values, beliefs, epistemology and ontology.

Mays & Pope (1995) describe typical criticisms aimed at qualitative research, furnished by the idea that it lacks scientific rigour. There appear to be three main accusations:

- Qualitative research is no more than the assembly of anecdote and personal impressions, and is highly susceptible to researcher bias;
- Qualitative research lacks reproducibility, because the research is so personal to the researcher that a different individual might come to radically different conclusions;
- Qualitative research lacks generalisability, due to the generation of large amounts of detailed information based on a small number of settings.

The answer to these accusations lies in the fallacy that science is simply a particular set of techniques; rather, science is a state of mind or an attitude, and relies on organisational conditions to allow this attitude to be expressed (Dingwall, 1992). The key to ensuring rigour in qualitative research is the employment of systematic and self-conscious

approaches to all aspects of a study. Mays & Pope (1995) suggest particular goals to be achieved in qualitative research, if rigour is to be ensured:

1. The creation of an account of the research process through which another researcher might come to essentially the same conclusions if they were to analyse the same data;
2. The production of a coherent and believable explanation of the phenomenon that has been studied.

To this end, and to address the issue of semantics in rigour, Bloomberg & Volpe (2008) suggest that several criteria should be employed in order to evaluate what they describe as the “trustworthiness” of research. As this chapter has demonstrated, issues of rigour have been highly significant in the study, and table 4.5, below, applies Bloomberg & Volpe’s criteria of credibility, dependability and transferability, and adds to this Lincoln & Guba’s (1985) idea of confirmability, in order to demonstrate how I worked to ensure methodological rigour.

Table 4.5 Demonstrating Trustworthiness

	Exemplars	This study
Credibility	Do the participants’ perceptions match up with the researcher’s portrayal of them? An accurate representation?	<ul style="list-style-type: none"> • Transcripts, themes and narratives seen by participants, opportunity to comment • Further interaction with online community to discuss emergent themes
Dependability	Can processes and procedures of data collection and interpretation be	<ul style="list-style-type: none"> • All field notes and transcripts available

	tracked?	<p>for review</p> <ul style="list-style-type: none"> • All analysis stages carefully recorded, available for review • Constant checking with academic supervisors
Transferability	Could a reader decide whether similar processes might be at work in their setting?	<ul style="list-style-type: none"> • Clear documentation of all processes • Research design explicitly described
Confirmability	Are findings clearly derived from the data?	<ul style="list-style-type: none"> • Processes of analysis demonstrated throughout • Analytic stages described from data collection to representation

4.9.2 Reflexivity

While research lacking in reflexivity might be considered ‘blind’ (Flood, 1999:35), the process of reflexivity is complex in nature, described as being filled with ‘muddy ambiguity’ (Finlay, 2002) in relation to researchers’ negotiation of self-analysis and self-disclosure. While reflexivity might be described in these cautious terms, I considered it a central element within the research, and describe the pertinent issues here.

It has been suggested that researchers should explore the ways in which their involvement in a study influences, acts upon and informs such research, recognising that it is impossible to remain ‘outside of’ the subject under study (Nightingale & Cromby, 1999). This exploration is a systematic process, which takes place at every stage of the research study

(Malterud, 2001) and involves constant questioning and reflection throughout the research process (Hertz, 1997:viii).

Willig (2001) proposes two perspectives within a reflexive framework:

- Personal reflexivity involves reflecting on issues such as personal values, interests, beliefs, experiences, wider aims in life, and social identity, in order to consider how such things may have impacted on the study. There is also a degree of self-analysis inherent here, in relation to how the research itself has impacted on the researcher;
- Epistemological reflexivity involves reflecting on how assumptions a researcher makes about the world and about knowledge might have implications for the research and its findings.

These ideas loomed large throughout the study. Evidently, as a midwife researching among midwives, I brought my own experiences of midwifery into the field. Having been educated in the importance of constant reflection during my midwifery training, I have long valued the art of critical reflection, and throughout this methodology chapter I have shown evidence of that reflection at work in the study. While personal insight can be valuable to a study (Malterud, 2001), it is essential that a reflexive stance is maintained throughout in order that the researcher does not confuse intuitive knowledge already held, possibly embedded in preconceptions, with knowledge that emerges from the systematic inquiry during the research process. A declaration of beliefs at the outset of a study helps to avoid this situation (Malterud, 2001).

As I described in the introduction, my role as a midwife has been central to the study, and I have intimated in this chapter the degree of reflection undertaken throughout the process. As I have described, the reflective skills I consider important in life generally, have been

valuable in helping me question my assumptions about, for example, the nature of knowledge, the ideal methods of data gathering in the study, and the interpretation of data arising from observations and interviews.

The outcome of reflexivity in research is 'reflexive knowledge', where there is insight on the workings of the social world, but also insight on how that knowledge came into existence (Hertz, 1997:viii), which echoes Willig's (2001) emphasis on both personal and epistemological reflexivity. Personal reflexivity has been significant throughout the study, and my research diary has been a place to consider such issues as Willig suggests may be relevant. As for epistemological reflexivity, I have applied a rigorous approach to consideration of the research methodology applied to the study, particularly in relation to my own assumptions about how knowledge might be generated. Hertz writes that the application of personal and epistemological reflexivity offers the research audience the opportunity to evaluate the researcher as a 'situated actor', that is, an active participant in the process of meaning creation (Hertz, 1997:viii). I have been explicit in describing my role in the study, viewing myself as a character alongside other characters (Tedlock, 1991). While there is some discomfort in the degree of self-disclosure associated with this level of reflexivity, I believe the study has indeed produced 'reflexive knowledge': I have offered insight into the world of midwifery leadership, but have also demonstrated how that insight came into being (Hertz, 1997:viii).

4.10 Conclusions

This chapter has concerned the research methodology, showing the importance of a strong epistemological stance throughout. I described and justified the various research methods employed, showed the clear links between them within the study's framework, and identified ways in which I addressed questions of rigour. The overview and description of

the analysis leads the reader logically to the next three chapters, which detail the findings of the study.

Chapter Five: The Path to Leadership

"I don't think it was accidental, actually. I've always been a doer, I've always – if there's been a challenge there, I will not be fazed by it, I will always look at – right, let's see what we can do with this, let's see how we can get round it, move forwards or whatever" – Deborah, matron

5.1 Introduction

The first data chapter details the interviewees' paths to leadership, from a role identity perspective. The main principles of identity theory are explored through interview themes, as well as through observational data and personal reflections from my own path and experiences. Themes include interdependence between self and the wider structure in career development; issues of identity transition and/or role accumulation; and ideas of commitment to particular role identities.

Given the individualistic focus of role identity theory, in this chapter I examine themes largely from the point of view of the individual interviewees. In the next chapter I will look more closely at identity transition and enactment from a social identity perspective, while in the third data chapter I introduce the counter-narratives of the online respondents, concluding with a somewhat surprising conjoining of themes.

This first chapter describes the interviewees' leadership journeys as far as 2012, with potential futures addressed in a later chapter.

5.2 The Path to Leadership

I began each interview by asking participants to describe their journey through the NHS to date. Interviewees were largely left to describe their careers in as much detail as they wished, with prompting as necessary. Table 5.1, below, gives an overview of the timelines

involved, and demonstrates the wide range of experiences and varied timescales seen in the narratives.

Table 5.1 Career timelines

	Qualified as nurse	Qualified as midwife	Current role	Other midwifery leadership, management and education roles
Deborah	1985	1988	Senior matron	HoM secondment
Lesley	1988	1994	Matron	Band 7 labour suite coordinator Midwifery lecturer HoM/general manager (forthcoming)
Natalie	1981	1984	LME	Labour suite sister
Pauline	1983	1986	Matron	Band 7 community midwife
Louise	-	1998	Matron (acting)	Ward manager
Heather	-	2003	Matron	Band 7 community midwife Band 7 labour suite coordinator
Caroline	-	1998	PDM	Lecturer practitioner
Karen	1983	1987	Matron	Lecturer practitioner Community midwifery manager HoM secondment
Susan	1978	1982	LSA MO	Community midwifery manager Head of midwifery

5.2.1 Decision-making

Various reasons were offered by the interviewees for making a transition to leadership. Some related to the interviewees from an individualistic perspective; for example, several participants mentioned the need for new challenges:

"I felt I was making changes in the university, but it wasn't making a big enough splash... So I started to get itchy feet about six years in, I – I looked at managers, and I could see very positive attributes in managers – in leaders, in midwifery. I knew who I wanted to be like, I just wasn't sure how I was going to get there" – Lesley, matron.

Interestingly, Lesley went on to successfully apply for a head of midwifery post between the two interviews, and was about to take up the HoM role when I interviewed her for the second time. Already, she was considering the future, and further challenges:

"I'm already thinking about that [moving on from HoM]. It's really bizarre. I'm already talking about [laughing] – it sounds bizarre. I haven't even started! I'm already talking about what I'm going to do next".

Heather, meanwhile, saw the need for challenges in quite different terms, which related to her self-perception:

"I do like to challenge myself all the time. And I think this fear of failure drives me really hard, because I have to be the best I can be, all the time".

Susan described the need for challenges in relation to her move from a HoM role to her current position as LSA MO:

"It's difficult, that one, to actually say what it is that makes you know – but I had – I guess things were no longer the challenge for me".

Alongside the need for challenges, the majority of the interviewees mentioned a sense of inner drive and motivation, again emphasising the place of agency in their career decision-making:

"I do sometimes think to myself, how did I get to this point and why am I doing this, when I qualified as a midwife and I should be on the floor just – I should be working as a midwife. But it would never have been enough for me, to have just done that, so I needed – I needed to do something on top of my midwifery training" – Caroline, PDM.

Alongside these individualistic reasons for moving to leadership, interviewees' career decisions also showed strong evidence of interplay with the wider organisational structures. For example, the desire to influence change was mentioned by most of the interviewees:

"And I do believe as well, that it's far better to be in there, actively involved, throwing your ideas in the pot, rather than sit back and be told, 'This is how you do it'. That's not my style. I would rather be in there, contributing and developing things" – Deborah, matron.

"I said, 'Oh', I said, 'we need to stop all this closed glottis pushing and cheerleader stuff'. And I was talking through about what I'd read, and again about management of OP [foetal position] as well – 'Oh, that's it then, you're going to push our forceps rate up!' And I thought, 'How can I change practice if I am working with that? Maybe what I need to do is go into education and try it from the bottom'" – Natalie, LME.

Natalie's sense of not wanting to accept the status quo, and of questioning the way things were done, was echoed by several other interviewees:

"It's this wanting to improve things, and looking for other ways of doing it, not just thinking, well, it's got to be that way. Why has it got to be that way? And why do we have to do it?" – Deborah, matron.

"I came out of management to go back into clinical practice, but then I moved out of clinical practice into management because I felt that there were things that were being done that actually I felt should be done in a different way. And it was either, then, shut up or actually get in there and get it sorted" – Susan, LSA MO.

While self-motivation was central to the interviewees' leadership journeys, encouragement from others also played a significant part. Pauline spoke of the influence of her supervisor of midwives and her line manager in making the decision to apply for a HoM secondment:

"[She] said, 'Well, what – you know, it's good development for you just to be exposed to the interview process'... She said, 'It will be good exposure for you, just to go into the – into a HoM interview to see what it's all about'. And so – so I spoke to my ex-head of midwifery, who I – who I've kept links with, and she said, 'What have you got to lose?' She said, 'It would be good exposure for you', so I went for it".

Deborah was able to reflect with hindsight on the influential role played by a former manager:

"I bumped into a previous manager of mine... And she said to me, 'So, what are you doing nowadays?' I said, 'I'm doing your old job!' She said, 'I always knew you would'. So you know, it's about having somebody there. And she did – you know, even though she was a devil at times, she did actually see potential in me, and encouraged me forward".

On the subject of encouragement from others, there was one dissenting voice among the interviewees. Caroline felt she had not had the encouragement from others to develop a career path:

“When I was qualified as a midwife, that’s what I was doing. I wasn’t really looking there, at that time, or wasn’t being informed at that time, that there were several pathways I could develop. I could develop into this, into that – and maybe rightly or wrongly, you’re not told”.

All the interviewees spoke about finding the right level at which they could effect change and influence service delivery. This realisation came at various points in their career journeys. For example, Deborah was already a senior matron, and completed a strategic leadership development programme:

“So after I’d done the RCM’s leadership programme, I came back sort of fired up, thinking, ‘I need to do something now, I need to go somewhere’. But at the time, there wasn’t the opportunity for a head of midwifery post locally, and there wasn’t much in the region either, and unfortunately due to family constraints, I can’t look at the bigger picture. So I bided my time”.

At the time of the first interview, Lesley had been in the matron role for several months, having returned to the NHS from a university lecturer position where, as described earlier, she had realised she could not effect the kind of change she wanted to:

“I became an NLS instructor, and an ALSO advisory faculty instructor, so I was doing a lot of networking, meeting with people nationally and internationally through those forums, and thinking, ‘I need to back and, you know, make changes’”.

By the time of the second interview, Lesley had become frustrated at matron level, and had successfully applied for a HoM position in a different trust:

“I guess I want my own service, I want to be responsible for the decisions I make. It’s a bit frustrating, sometimes, delaying things because you have to escalate it up... There’s due process to go through, and I just find that a little bit frustrating. I could be completely wrong, but I feel I’m ready for it [the HoM role]”.

While Pauline found this ability to make a difference at matron level, rather than Lesley’s HoM role, she described it in similar terms:

“[I get] more satisfaction now, because I’m in a position where I can make a difference – more of a difference than you can as a band 7. The band 7, you can only go so far, and then you have to, you know, pass that information up – up the ladder, if you like, for them to actually take note and decide whether they want to do something about it or not. I’m now in a position where I can make that decision, whether, you know, it is a good thing to move forward, whether it’s something that we need to be taking note of and making changes, and listening to the women”.

Endogenous and exogenous factors are clearly evident in decision-making. Interviewees were able to identify that they often wanted ‘more’ from midwifery, and they showed an awareness that change can only be effected at senior levels of a management, strategic or academic hierarchy. Alongside an emphasis on their sense of inner motivation and drive, interviewees generally described a good deal of encouragement from others in the decision-making process, usually from individuals above them in the organisational hierarchy, who seemed to encourage them to consider things from a position of ‘Why not me?’ when contemplating a move into leadership and management.

5.2.2 The Place of Self-Reflection

All self-descriptions suggested the importance placed by interviewees on reflection. This was demonstrated in various ways, including identification of their strengths and

weaknesses, and the place of reflection in leadership. Table 5.2 (below) gives examples from each interviewee of their self-description, and key elements mentioned by them.

Table 5.2: self-descriptions

Name	Key elements	Example
Deborah	Action-led, analytical, decisive	"I'm not an extrovert, but if I feel very strongly about something, I will do it and say it, yeah".
Lesley	Self-confident, challenging, enjoys being challenged by others	"I never had a problem with self-esteem, put it like that, because of the way I was brought up. I was brought up to think, 'You can do as well as anybody else what you want to do, but you're no better than anybody else'... I was always being sent to Sister's office [as a student] for challenging or suggesting different ways of doing things".
Natalie	Highly self-reliant, sometimes closed	"I came out with 100%... in one area [of psychometric profiling]... And I thought, 'Well, yeah, that's fair enough', and they thought it was a real negative. Now, it was actually 100% for self-reliant".
Pauline	Open, honest, transparent, empathic	"You know, what you see is what you get. This is me, you know. I can be direct, I'm never rude, but I am direct, because I'm a northerner, black is black, white is white, you know".
Louise	Shy, lacking confidence, relishes challenges	On presenting at a conference: "Absolutely didn't want to do it, because I'm not that – really not that sort of personality. As a student, having to do those, sort of, presentations in front of your own peers was the worst thing ever. Ever, ever, ever (laughing)!"
Heather	Fears failure, needs to be liked, challenging, highly reflective	"I have a real fear of failure, and it governs, I think, everything that I do. I don't like to fail at anything, and if I feel I'm not being effective, or I've made a decision that hasn't been a good one, I – yeah, I struggle with that, internally".
Caroline	Takes ownership	"I went out and got that [role], I looked for that, because

	and responsibility	it was in <i>me</i> that I needed something else”.
Karen	Reflective, thoughtful, values integrity and consistency	“I’m the sort, I need time to think about things, and whenever we’re in a group meeting or something like that, there will be people that are firing opinions about this, this and this, and I’ll be mulling and mulling and mulling”.
Susan	Needs challenges and stimulation, resilient, politically savvy, dislikes conflict	“I don’t think I was particularly challenging, I – not from a personal point of view, because I’m always been someone – I don’t like conflict, I like to resolve conflict. So I, you know, I would never say that I had a degree, I would never, you know, sort of, anything like that, but I would do it quietly”.

From the descriptions in table 5.2, there is no single character ‘type’ emerging from the interviewees’ self-characterisation. Rather, they described how they have utilised their various strengths and weaknesses – or indeed, fought against them – in their career journeys and in the enactment of a leadership role. Louise, for example, identified herself as lacking in self-confidence, and highly reflective. But knowing this about herself, she has been able to make career decisions:

“One thing I have realised is I like setting myself challenges, as much as I think, ‘Why am I doing this?’ But I do. I keep going and – going with the challenges, and I suppose I don’t sort of give up on them completely. I’d probably just think a bit more about it”.

Interviewees identified self-reflection as a key element of leadership. Deborah described times when she had to change plans:

“It’s about finding that right path, and it’s about also acknowledging when you set off down a path – if things aren’t going right, and basically, you know, you can see

it isn't going to deliver or get you where you want to be, it's about being honest and saying, 'Whoa, I don't think we're quite getting it right, here, let's stop, have a re-think, and take an alternative route'.

Karen, meanwhile, considered ways in which her reflective nature had impacted on her leadership style. She described how she has come to terms with her own character, relating this to her behaviour in group meetings:

"I'm the sort, I need time to think about things... And then, at the end of the meeting I'll say, 'You know what?' Or the following day, it'll be, 'You know yesterday, when we were talking about so and so?' And out it'll come. And I always used to think, 'Well, I want to be one of them, that can, you know' – but I've realised that I don't really want to be one of them, I'm quite happy sort of thinking about what I do and... Yeah, and that there is a place for people like that, within that. There still needs to be somebody that can sit back and think".

5.2.3 Moving Along

Interviewees appeared to have gained a realisation of the bigger, strategic picture through exposure to it, generally during periods of specific development – such as during supervisor of midwives training, or on leadership development programmes:

"That [the wider structure] only became apparent to me when I did my supervision training, to be honest... I mean, I suppose, [the head of supervisors], for example – we didn't know [her] until I did my supervision... And the only time I would – prior to that- see her, or be aware of her, was when she would come to do the audits that – the annual audits and things. And you hear about – 'Oh, [she's] here', but it didn't really mean anything. But I suppose, as well, [she] has – with this course, and also with the supervision training – become more visible" – Pauline, matron.

In normal work time, matron level appears to have been the place to begin to see how the NHS organisational structures operate:

“And then you get to my level, where you begin to start dealing with commissioners, and you begin to see where maternity sits in the broader corporate context” – Lesley, matron.

Louise provided a useful contrast with life as a band 7 ward manager, as in the second interview she had made the decision to remain a matron, having initially been seconded to the role:

“As I say, making that decision to go for the substantive has kind of made me conscious that – a step back, as much as it would be an easy transition to kind of – you can do the job, and you wouldn’t probably moan about it as much (laughing)”.

Heather provided a further insight into the difference between band 7 labour suite shift co-ordinator and matron roles, after applying unsuccessfully for a matron position:

“They said that, you know – the person that got it had more strategic knowledge, and a better understanding of budgets and finance and how maternity services were run, what was influencing practice. Although I felt I had quite a good understanding of that, but I just realised that was something – and also, I’d also realised that actually I would see it – as long as I got that, as long as I learned about that – I would probably be ready for the next stage”.

The reflection below, ‘Hot topics, pens out’, illustrates the point that roles were not clear cut, with differences in understanding of what ‘management’ was in the context of clinical leadership roles.

Hot Topics, Pens Out

I'm at a study day for the band 6/7 leadership programme, the band 8 programme now having been completed. The atmosphere is lively and positive, the familiar feel of a day taken illegally from life at the frontline. The midwives comment frequently (as ever) on the elegant surroundings, the good food, the chance to get away from clinical stresses.

I'm at a table populated by midwives from across the region, a mixture of band 6 and band 7, which includes midwives from both hospital and community settings. At some point, a discussion begins amongst them about the fact that the band 7s feel they are middle managers. I assume they must be ward managers, but on further inquiry it turns out they are labour ward shift coordinators. Middle managers? In my mind, middle managers are matrons, heads of midwifery, perhaps even ward managers – but not those coordinating shifts on a day to day basis.

Later in the day, a presentation is underway. The facilitators introduce a slide entitled, 'Hot Topics in the NHS'. Instantly, there is a ripple of movement as every delegate reaches for pen and paper. It becomes clear that much of what is being shown is new to them – and these are strategic and policy issues. I'm reminded of an action learning session on the band 8 programme. Here, there was a lively discussion of the benefits and challenges of the incoming clinical commissioning policy, and I felt rather lost and uneducated, not really knowing enough to join the discussion and being terrified that I would be expected to do so.

The contrast was clear, and is in fact echoed in the data above: those at band 7 might believe they are part of middle management, but their lack of awareness belies the fact that the bigger, strategic picture is further away than they might think.

Interviewees, acting as agents in their own careers, spoke of how awareness of a need to learn more of a strategic leadership role led them to ask for more in the way of organisational support, taking charge of their own development. Heather was particularly reflective about her realisation that she would need a role in which she could learn more of the strategic picture, after her unsuccessful matron application:

“So when I didn’t get that, I was really, really shocked, and it did take a bit of – I suppose it knocked my confidence a little bit as well, because I suddenly thought, ‘Well, here I am, thinking that everybody thinks I’m this really good midwife, and actually I’ve got these massive holes’. And I was wondering actually, have I gone up like this [indicates steep incline] and I’ve missed all these gaps in practice”.

Heather went on to describe a secondment to service development, where she was given new responsibilities and learning opportunities:

“So having – okay, it was only six months, but it was a very condensed six months, and all this information – I almost felt like somebody had opened the doors and sort of led me [through]”.

While there were times of deliberate self-development, the most common exposure to the wider organisation was described by the interviewees in terms of experiential learning.

This learning had both positive and challenging aspects:

“[BD: And how did you learn this role? By doing it?] Yeah... There’s no two ways about it. Baptism by fire, it was. [BD: Yeah. Would you rather that didn’t happen for the next people that –] I think it’s very important that it doesn’t!” – Natalie, LME.

While Natalie described a ‘baptism of fire’, Pauline spoke in more positive terms, for example in relation to learning about budget management:

“Well, you bring it down to your level of understanding and how you – I mean, you get guidance from the accountant and the finance department”.

All the interviewees identified the significance of gaining understanding of and exposure to the wider organisational structure from the perspective of individual career progression:

“Because a leadership role never stops. It always evolves, it will always grow... Which is all new, you know, but... to me, it’s all part of the job, it’s all part of the role, an evolving developing role, which is fantastic. And yes, if I do choose to go on the path to become a head of midwifery, I need to know all of this” – Pauline, matron.

Louise described the importance of understanding more than just one’s own work, if a narrow view is to be avoided, speaking in relation to midwives applying for ward-level managerial roles:

“And it was ironic, when I sat down with some of the candidates that were going to go for it, and was sort of chatting to them about what the role entailed – what the role was all about – and it’s very much that impression of, ‘Well, someone’s sat behind a closed door doing nothing’, and they had no idea. And they were absolutely floored by the extent of the work that I was doing, and had no idea that that’s what it entailed. Because I think you do, you get very... You just see your role, and everybody else’s doesn’t have the same impact as yours, I think”.

This part of the chapter has given a strong sense of the interviewees acting as individuals, but always within a wider hierarchical structure. Exposure seems to be key: knowing they wanted more from midwifery was not enough – they needed to see what possibilities existed. The next sections deal in greater depth with the structural mechanisms that supported the interviewees to do this.

5.3 Wider Structures at Work

Various elements played a part in the interviewees' narratives of a journey to leadership. Previous sections dealt largely with them as individuals, driven for a variety of reasons to make a transition to leadership and management roles. All the narratives, however, were characterised by an interaction between them as individuals (agency) and as participants in and members of a large organisation (structure). The following sections explore ways in which exogenous factors were influential in the interviewees' leadership journeys. Factors include organisationally-supported structures such as leadership development programmes, coaching and secondment opportunities.

5.3.1 Leadership Development Programmes

For the majority of the interviewees, the LMS programme represented their first experience of formal leadership development, despite their relative seniority in terms of leadership role enactment. One interviewee, Deborah, had undertaken the RCM strategic leadership programme in the year before LMS, while two others recalled having attended the Leading Effective Organisations (LEO) programme some years earlier, but had found it uninspiring, perhaps because of its broad brush approach to the development of all nurses and midwives:

"Now, I don't think it really – it was there, but I don't think it was something that I would reflect on and utilise... And because it was all multi-disciplinary, you had nurses, you had all different professions. And I think it's because – our role is different to a nursing role, and we are more advocates for women" – Pauline, matron.

The interviewees identified both positive and negative aspects to the timing of LMS. There were mentions of the idea that, had the programme been offered earlier in their careers, they might now be making more ambitious career plans:

"If I had done this course years ago, I think it would have been so much more helpful to me... The stage I'm at, I've only got 15 months left in my career, before I retire, so for me, I feel I've – I've had several careers over my life, and I've done – done a lot. If I was ten years younger, I'd be looking to where I would be going next. I would probably be thinking, right, do I want a consultancy post?" – Caroline, PDM.

While Karen felt the programme might not have been ideally timed in relation to her own career, she could see that it would be useful for those facing a time of career decision-making:

"I think for me, as – as I was getting to that stage where I'd been out on community for a while, my children were growing up, and I'd reached that place and thought, I love what I'm doing as a community midwife, I could stay here until I'm 60... so I can keep going on this route, it's quite comfortable, fits in well with my family and my life... Or, I'm at this crossroads, and now is the time to – to do something different. I was doing my supervision course, got the secondment into the lecturer practitioner post, so obviously getting an idea of the – the politics around education and this sort of thing, so I think at that stage, that would have been a good time".

Similarly, those participants just beginning new leadership roles felt the benefit of LMS being timed to coincide with a role transition. Lesley was new in the matron post when she discovered the existence of the LMS programme:

“A very good time, really, because I was thinking about what I wanted to do here, and change, so it enabled me to really focus”.

Various benefits were identified in relation to leadership development programmes in general, and LMS in particular. Benefits related to the interviewees as individuals, but also within the group and organisation-level structures. On an individual level, the programme was seen as an opportunity to identify and work on one’s own strengths and weaknesses:

“I’m not sure it taught me anything new. What it did was help me to develop resilience. Helped me to tap into the strengths I already have, and maybe just work on the limitations” – Lesley, matron.

There was a strong association with an increase in confidence:

“The course has definitely been a catalyst. It’s given me confidence again, in myself, because – I think I said to you before – where I had – where people on a personal, professional level have made me feel I wasn’t any good, and I wasn’t capable, after a while you believe it” – Natalie, LME.

Deborah reflected on the confidence boost the programme had given her, in relation to applying for new posts at HoM level:

“I’m stronger, hopefully so, yeah. Because to me, that shows that I have actually gone out there and put my head above the parapet... I’ve actually gone out there and said, ‘I’m game for this, I’m up for this, and I will actually, you know, do it, basically, because I want to develop, I want to take things forward” – Deborah, matron.

For several interviewees, simply being ‘away from the coalface’ was identified as a benefit of the programme:

“I found – the luxury of having time to think. Wonderful! In fact, almost to indulgence, where I felt guilty (laughing). Because I felt I should be doing – well, you know, the timetables, or ‘I must follow up that student query’. ‘No, you can’t. You’re here’. ‘Yes, but’ – That! And I think a lot of us found – I mean, did find that so rewarding. Having that space and that time to think. And actually, looking at yourself – when you don’t look at yourself... So that was – that was good, and having time away was pure luxury” – Natalie, LME.

The chance to grow a network of fellow clinical leaders was identified by all the interviewees. Generally, advantages were described in terms of sharing experiences and learning from others:

“The interaction, and the learning from others, which is always great, it’s always a wonderful thing to learn from others. And because we’ve all got our own journeys and our own stories and our own – we’ve all got our own knowledge of what we do, and that sharing, and that – discussions in groups... Peer support, from the group discussions” – Caroline, PDM.

Pauline described how she selected individuals with whom she would like to network, having made particularly close connections with one of the HoMs on the programme:

“Maybe it’s their personality, maybe it’s their mind set, how they come across as – as a leader. Whether it’s their personality as in approachable – and similar mind set to yourself, because you need somebody who understands where you’re coming from, and sees where you want to go. And because they’re at another level, they can actually share their experiences, their knowledge”.

Lesley made the point that networking is often not thought of as a priority in normal work time:

“As midwives, I think it’s historic. I think we’re so busy, keeping our heads down and trying to get on with the day to day work, there is no room in our professional lives. And it doesn’t come – networking comes too late, it doesn’t come until you’re a head of midwifery. And then you have that ability to meet with your head of midwifery colleagues, to network – but down the ranks, it doesn’t. So that networking was fabulous, and that opportunity to know that other people were having the same problems, and to look for solutions together”.

One of the LMS pathways included a residential element, which was seen as beneficial by those who attended:

“I learnt a huge amount, and you left so enthusiastic from each session, particularly the residential ones” – Louise, matron.

Two interviewees who were on the non-residential pathway expressed the view that they would have liked the additional ‘bonding’ and networking experience gained through residential, which emphasised the value placed on building networks and relationships:

“I would probably say it was less – we had less opportunity in pathway B than pathway A” – Lesley, matron.

LMS was clearly seen as a positive learning and networking opportunity by the interviewees for a number of reasons. They described feeling energised and motivated by the experience, but the challenge after completing the programme related to keeping networks going and maintaining enthusiasm.

There was considerable variation in interviewees’ experiences of keeping their new networks going. Deborah had been in touch with a number of other LMS delegates, and described the benefits of doing so:

"It definitely helps, because you know if you get to that point where you're stuck, it's – it helps with all the benchmarking stuff as well, knowing what's going off elsewhere, and if you – very often, if you've had that problem, somebody in a neighbouring maternity unit will have had the same issue".

Caroline felt the challenge lay in finding time to continue with networks:

"We did [keep in touch] at the start, but it's fallen away a bit. The emails are all – the email addresses are all still there, it's just that I think that at the end of it... We all felt – we did email back and forward, and whatever, but I think we've all gone back to our own places now. We've all got back into our own work and whatever, so I haven't heard from any for a wee while now, and I've not emailed anyone, so I can say it's probably fallen away now".

Several of the interviewees mentioned a lack of continued communication from the SHA through which the programme originated:

"I had some bits and pieces, but I've not heard anything from them for a while... And I kind of expected more stuff... It seems to have gone very quiet. There was a flurry initially, and then it's quietened down, really. And I suppose, in the same way as all the other things, you – you think, 'Oh, I'll think about contacting somebody', but that time never really comes" – Louise, matron.

On bringing learning into practice and maintaining new-found enthusiasm, Deborah described the challenge of trying to enact leadership learning when returning to the usual stressors of the workplace:

"It's the same old frustrations of time, resources, and you just start to do something and somebody pulls the rug from under your feet. And also, you have your plan in place, of where you want to go, and then something will come out of the blue on

top of it, and it's like, you think, 'Oh, please don't', because, you know, you just want to keep focused... Yeah, it will all stop, or fizzle out, the momentum will go. And I think that's the biggest challenge thing as well – keeping the momentum going. It is so hard – it's draining".

Opinions varied on the general value of leadership development programmes. While most interviewees identified many positive aspects as detailed above, there was something of a doubt as to whether leaders can be 'constructed':

"Like no matter how much you educate and train somebody and give them experience and support and leadership and guide them, some people just haven't got the intrinsic autonomy, that self-belief" – Lesley, matron.

Similarly, Heather wondered whether a LDP could offer everything needed by particular individuals:

"I mean, I'm all for development and these leadership programmes. But I don't think they're right for everybody, I don't think that's particularly right for – you know, the programme pathway that I was on wasn't particularly right for me".

The impact of leadership development programmes can be identified at individual level, through personal learning and reflections; at group level, through shared learning and networking; and at organisational level, through the opportunity to develop and support leaders to be 'ready now' to fill leadership and management roles. Interaction between individuals and the organisation is particularly clear in the aftermath of a programme: interviewees expressed a desire to maintain newly-formed networks and relationships, but found this hampered by being subject to the usual pressures of the work place.

In the case of LMS, the SHA appeared initially keen to keep networks of leaders going, but since the end of the programme there have been significant changes within the

organisation – of structure and personnel – which may mean priorities and commitments have changed. To date, the programme has not been repeated. Added to this, the programme was delivered off-site. At trust level, it would be interesting to discover what degree of awareness existed as to midwifery leaders attending the programme, as this might have an impact on the level of support offered in relation to bringing learning back to practice. Whatever the cause, the interviewees' sense that the organisational structure had been unsupportive in maintaining momentum after the programme ended is significant in relation to the individual-organisational interplay in leadership development and enactment.

5.3.2 Coaching

Five of the participants have had access to one-to-one coaching – the majority via LMS, although Heather's coaching experience came after she identified challenges herself, coming into a matron role.

Those who have experienced coaching spoke of it in very positive terms. There was a similarity with the LDP experience, in that coaching offered time for self, away from the workplace:

I said to her [the coach] one day, 'I feel all I need is a bottle of wine on the table, really', because it was just like sitting with a friend. And it's amazing – I don't even have the opportunity she gave me, with my husband, because it literally was an hour and a half about you. All about you" – Lesley, matron.

There was also mention of coaching as an outlet for problems and frustrations:

"And I found that the coaching was really good at giving me a different view, so if I'd got an issue, I could – so I suppose I was offloading that issue. We'd talk about it, and then [the coach] was very good at saying, 'Yeah, but just think about this

other side, and look at it from here', which sometimes when you're in the thick of things, you don't get that time to lift your head up and 'Do you know what? I need five minutes to think about this'" – Karen, matron.

Pauline was enthusiastic about the tailored guidance she gained through coaching, although she struggled initially with the necessary level of self-disclosure:

"I've had to expose myself, yes... Sometimes for you to develop and progress, you sometimes have to let people in.... That person may be able to help you to develop in ways that you may not even be aware of, and it's only when you sort of open up and sort of say how you're feeling, how it's affecting you when you reflect on things, how – where you feel you're at, that they can then offer support, advice, information, guidance, direction as to where to go, what to do – which is what happened".

Like Pauline, Heather described the benefits of coaching in relation to reflection, dealing with difficult situations, and career progression:

"It's really looking at skills that I feel I need, so I can progress to the next level. We just discuss those. Sometimes I'll bring difficult situations, that I don't think maybe I – I maybe feel I could have handled better, so it's reflection as well, just learning from her experience. And that's been very, very useful, actually, dealing with more challenging behaviours. I've learnt a lot with that, and that's been very effective. It's – when – yeah, really when I've been looking at other roles to – to go for, I've – we've discussed those".

The chance to learn from another's experience was also considered a significant benefit of coaching. Karen described this in relation to the coaching coming just as she began a new role, and at a point of change within the unit where she was working:

“And that wealth of experience that she’s got. So she, you know, understood exactly where I was coming from within, you know, suddenly I’m in this new role, and we’re in this new building, and you move in and think, that’s a new building! It’s the same service, but what a difference it made. And at one stage I’d felt that the bottom had really dropped out of things, you know, so that time was really good, to be able to just get away and think, oh actually, it’s not as bad as I think it is”.

Lesley was particularly enthusiastic about coaching, although she saw a challenge in the relationship, with the coach as professional rather than as friend:

“I think if I really needed to find out something from [the coach], she would reply. If I said, ‘Please could you’ – or if I rang her, that would be good. But you know, you have an understanding that that’s their job”.

Again, coaching speaks to the needs of individuals and organisational structures in leadership development. Individuals appreciated the tailored approach offered by coaching, as well as the supportive structure and space away from the workplace. At the same time, the organisation is able to use coaching in preparing the next generation of leaders. From the individuals’ perspectives, a continuing model of coaching appeared the ideal, but in most cases, organisational support through coaching was offered for a short period only.

5.3.3 Secondments

Six of the interviewees had experienced secondment opportunities at various points in their careers, and had found the experience a positive one, although not without its challenges. The most commonly expressed benefit related to gaining exposure to previously unexplored elements – at personal and organisational levels. Pauline, who had a

secondment to matron after many years as a community midwife, discovered her own capabilities:

“Because before then, I’d have thought I could never be a matron, I could never do that job. But when I was in it, I did not see it as challenging, I thought, ‘God, this is easy!’ (laughing)... and you know – and all the skills and knowledge that I had built up over the years, it just flowed”.

Caroline, who had been a direct entry midwife, took on a lecturer practitioner secondment three years after qualifying. She described the impact at structural level:

“Because that’s when the bigger picture was opened up for me – of seeing all these other things going on within midwifery, and areas that – that I got to know about. Nursing meetings that I’d gone to, which had a relevance on midwifery, and that midwifery wasn’t just stand alone, and it had – you had to interact with all these other – other professions”.

A common theme was a sense of experimentation associated with secondment roles. Louise felt this experimentation was essential:

“I think when I was going into it, you have to do – you look at it as sort of a try before you buy, and – to get a greater understanding. Because the only way you can get that – as I said earlier – greater understanding, is actually to do it”.

Linked to the idea of experimentation, interviewees felt that secondments helped them to make informed decisions about next or future career moves. Pauline found the matron secondment an ideal chance to discover where she might go next:

“At least with secondment, you’ve got that movement, and you can sway one way or another. You can either – you can also, sometimes, identify where – where you

are, or where you want to be, which direction you want to go in. That's the space where you can make those choices, isn't it?"

Deborah had a year-long period of secondment as part of the LMS programme, which held particular challenges, based largely on the fact that the secondment was to a different maternity unit:

"It was very much like taking on a new job. New travelling arrangements, new city, new site, new estates, everything was different, all the processes were different... There wasn't much that I could go into and think, 'Oh yeah, this is the same as we do it'. Everything was different. Meeting structures were different, admin support was different – just all the nitty gritty. But as it developed, I felt more comfortable".

Interestingly, secondment opportunities did not necessarily lead automatically to interviewees wishing to take on a role permanently. Caroline explained that her initial excitement in combining teaching and midwifery via a lecturer practitioner secondment was short-lived:

"And that, for me, was like, my God, I could combine the teaching and the midwifery (laughing), so it was like – it was Heaven! And I thought, well, that's great, because it would then give me a taste of the – the lecturing and the – the teaching side of it, and I thought that's what I wanted – I thought, midwifery teacher, fantastic, that's both of them combined. And it was very good that I did go into the lecturer practitioner role, because it made me realise it's not – it wasn't what I wanted. So I was very grateful for having had the opportunity... Once you see behind the sort of – the gloss of it, the excitement of it – it just wasn't what I wanted to be".

In a similar way to development programmes and coaching, secondments can be examined at individual and organisational levels. For individuals, there is the opportunity to 'try out' roles, seeing what is available and desirable to them, and offering the chance to make informed decisions about career moves. For the organisation, secondments offer the chance to develop individuals within particular posts, suggesting a further 'ready now' succession planning strategy.

5.4 Significant Others

As well as structural mechanisms, interviewees described what might be termed 'significant others' in relation to their career journeys. These individuals took the form of mentors and role models, and they appear to have had significant influence over the interviewees' careers.

5.4.1 Mentors

Almost all the interviewees described mentors who have acted as guides during their careers, in relation to providing encouragement and feedback when required, but also in more obviously formalised ways.

Generally, mentors as guides appeared to hold line management positions, the most commonly cited being the head of midwifery. This suggests a strongly hierarchical approach to development, with mentors having offered encouragement in relation to specific career opportunities. Lesley spoke of the role of mentors in her decision to come back into the NHS from university life. She had misgivings about the matron role, as it was based in a unit where she had previously struggled with the management structures:

"I became very friendly with [a professor of midwifery] – and again, he's become a good friend, but also a good professional leadership figure... for me, really. And he'd been saying for years, 'For what you want to do, you need to get back into the

NHS, you need to get back there'. And actually, the head of midwifery, who was one of my fellow supervisors, told me this job was coming up, and felt that I would be right for the post... So I rang [the professor], and discussed it with him, and he said, you know, 'What are your options? You run away, and you don't accept the challenge, or you go there and you change everything that you didn't like about the place, and you move it forward'.

As well as time-specific encouragement, mentors had in some cases been advising interviewees over a long period. Lesley described mentors she has admired since her student days:

"The biggest influence on me as a midwife were the mentors I got in my first placement. The first birth I ever saw was a homebirth, and I had these two amazing influences as mentors – strong, independent women, with a culture and a philosophy of midwifery that was just very simple and straightforward... And they continued to support me, right the way – in fact, I'm still in contact with one of them... Those mentors were almost like my gurus throughout the last 20 years".

Like Lesley, Louise mentioned the encouragement of mentors throughout her career to date, although her lack of confidence in her ability meant she expressed their role differently:

"I feel like I've kind of cheated in a way (laughing). I've not earned it in the same way as others may have done – I haven't done it without somebody kind of saying to me, 'You should go for this'".

Mentors were also identified as highly significant individuals during secondments:

"I think the key role in the secondment for me, within my leadership development, was I had one – a weekly one to one session with my head of midwifery... I had a

one to one mentor relationship with her, and that has just been invaluable. It's just been absolutely amazing, because of her leadership style, and her management style, which is one that I emulate. And she gave me the inspiration to then develop further, to be honest with you. That's where it all started" – Pauline, matron.

Mentors continued to exert influence in the interviewees' current clinical leadership role.

Louise described the mentorship from her head of midwifery:

"I have fortnightly one to one meetings with her, to talk about how things are going, what sort of things we need to progress on".

Mentors held formal and informal relationships with the interviewees, but for the most part were in a line manager position. This is perhaps suggestive of an organisational-level interest in the development of individuals, with line managers recognising the value and importance of encouraging the next generation of service leaders. Mentorship appeared positively received by the interviewees.

Caroline, however, stands out in discussions of mentorship, as she described a lack of support. Hers was a contrasting narrative, with descriptions of having sought out support in an unsupportive environment, and where self-motivation has been her driving force:

"And I think... in all aspects of our service, in maternity, in leadership roles, in whatever role you're in, it's not – it's not easy, because... nobody makes it easy – nobody makes it easy for you, and you have to fight your way".

5.4.2 Role Models

The place of role models was closely linked to mentorship. However, while mentors were universally spoken of in a positive light, role models were seen either in terms of individuals the interviewees aspired to be like, or as those they were determined to be different from.

As with mentors, the most commonly cited role model was the head of midwifery, and again as with mentors, role models figured at various points in the career narratives.

Interviewees identified various mechanisms through which role models might be positively regarded. For example, they were considered a means of learning leadership behaviours, which Deborah believed were not confined to individuals in formal position of authority:

“Also having role models from – not always thinking it’s got to be a senior manager as your role model. You know, I’ve got some colleagues who work clinically, who work – you know, some of the support staff round the way – who – like some of the receptionists have got fantastic communication skills and people skills, and it’s just learning from them how they actually handle things on a day to day basis”.

Pauline described how she considered the actions of her role model (the head of midwifery) when enacting leadership in her own role:

“I utilise – I emulate her skills and her approach a lot... Because when she had to do the configuration, and reduce [band 7 community midwives] from 45 to 14, it wasn’t easy, but she did the change management to a tee. And I’d just finished my degree, a few years before then, and one of my modules was change management, and that was a prime example of how to do change... It was perfect, to a tee. And so therefore, what a good example have I got, to – whenever I’m introducing change, to follow that approach, and so far, I can say that it’s always worked”.

However, interviewees suggested that role models could be complex, and that they might not wish to draw on some of their characteristics. Louise described picking and choosing qualities of role models:

“I think that’s kind of been all the way through my career. As a student you do – you get exposed to lots of different people, don’t you, throughout... actually, you

can gain a lot from a mixture of people, and you can identify the good and bad in – in both their practice, personalities, and the way they deal with the general public. And you have to make those conscious decisions of which bits of those you're going to pull out to influence the way you care for women, it it's clinical practice – or the way that you behave in clinical practice – and your profession”.

Clearly, there are strong links between mentors and role models, with several interviewees describing the same individuals in both categories. Role models are more complex than a dictionary definition might suggest. For example the Oxford Dictionary online definition of a role model describes ‘a person looked to by others as an example to be imitated’, but the interviewees also mentioned characteristics that were considered somewhat undesirable.

To conclude this section of the chapter, which has dealt in depth with the interviewees’ leadership journeys, it is apparent that there has been strong interaction between them as individuals and in relation to the wider structures throughout their careers. Interviewees identified self-motivation, significant others, and organisational structures all playing significant parts in their journeys, with no single element taking primacy over another. The next section explores interviewees’ thoughts on their current role identity.

5.5 Identity Acquisition or Transition?

So far, I have explored the journey from clinical practitioner to clinical, strategic or educational leader. The final part of the chapter looks at the interviewees’ conceptualisation of their current role identity. I examine what role identity they are most committed to, and how they express and justify this commitment.

5.5.1 A Midwife Through and Through

Without exception, the interviewees defined themselves as midwives. They were able to offer a clear rationale for this self-definition, and spoke with considerable passion on the subject. Susan described how she was still 'doing' midwifery, but on a larger scale:

"I absolutely am a midwife through and through. I am a midwife who recognises her scope of practice, and I mean an enhanced scope of practice – my expertise is no longer in the actual delivery of individualised clinical care. My expertise is in the macro-midwifery. And I think that's one of the things we get hung up on, and why people say they don't want to be heads of midwifery, because they're not doing midwifery any more. And actually, they are"

Similarly, Natalie saw her LME role as midwifery in a wider sense, continuing to self-define as a midwife despite not having practised clinically for a number of years, and being based within a university:

"I would still say I'm a midwife... Because I feel passionately about the job".

Several interviewees described being still guided by midwifery principles:

"I filled the census in, actually, the other day, and I thought, 'What shall I put down?' I said, 'I'm a midwife!' And then it asks you for more description, so I put 'NHS manager'. But ultimately, yes, I'm a midwife. It governs what I do. I mean, I think every – Somebody once said to me, when you're making decisions, if you always think of the woman and the baby as the focus of those decisions, then you can't go wrong. And to me, that's what it's all about" - Lesley, matron.

While Pauline spoke of being a continued advocate for women, Louise described being an advocate for *midwives* in her current role:

"I suppose the way I've kind of gone about that is, you do have to leave some of it behind. But then your focus becomes much more on changing the – the elements of the staff, so supporting them with providing care, so that you may not be personally providing care, but you kind of support and encourage to make sure that, I suppose, the legacy that you've left of what you did, carries on".

Deborah spoke of her core identity being unchanged by a clinical leadership role:

"I'm still a midwife, you know, I am a midwife. Midwife runs through everything that I do. However, I focus on delivering a good service, a safe, quality service, and be that working with the staff or with the users, or the other agencies and the trust, that's where I see my role. But at the end of the day, I am still a midwife".

The question of self-definition was obviously highly significant to the interviewees. They remain committed to their professional identity, and have incorporated elements of their current roles into that identity. I will return to this central issue in the second and third data chapters. In the second, to discuss questions of credibility with frontline staff; and in the third, to explore whether their self-definition is validated by clinical midwives.

5.6 Conclusions

In this chapter, I have detailed the leadership journeys of nine midwifery leaders from a role identity perspective. The place of agency and structure in a transition from clinician to clinical leader has been demonstrated, where both have been significant, neither has primacy over the other, and the interplay between them is clear.

Having made a transition, it becomes clear that the interviewees remain firmly committed to a midwife role identity. This is achieved through a mechanism of expanding the scope of a 'midwife' definition, to include leadership, management and education elements, and the interviewees provided a clear defence of and rationale for a continued self-identification as

midwives. While from a role identity perspective, with its individualistic focus, it seems logical that the interviewees retain a midwifery identity, in the next chapter I highlight a more complex issue: maintaining the midwife identity from a professional and organisational group perspective.

Still a Midwife?

It's four years since I worked clinically, and yet I continue to call myself a midwife. Over dinner at home, this is a regular topic of conversation. My ten-year-old can't understand how I can call myself a midwife if I don't work with women and babies. I can see her point, if that's how she defines midwifery. And to be honest, part of my fear of academia is based on a worry that I will lose the midwife element of my identity if I don't maintain a close connection with the NHS.

Last year, I renewed my NMC registration in preparation for moving out of the business school and back towards a world of midwives – registration is necessary in any midwifery-centred role, whether it is in practice, education or academia. I was happy to be able to justify my self-definition as a midwife, as per the NMC's re-registration requirements:

1. 'You must have completed 450 hours of registered practice and 35 hours of learning activity in the previous 3 years';
2. 'Practice can include supervisory, teaching, research and managerial roles as well as providing direct patient care'.

I like to quote these requirements at my children whenever they question my midwifery self-identification. And I tell them what the interviewees said: doing midwifery, just on a bigger scale or in a different arena. But there have been challenges to this self-definition during the past four years, and at times I have felt far from 'being' a midwife. When I've been standing in front of PhD students at Warwick, identified as 'business school student'; when I've been explaining my work to family and friends, identified as 'researcher'.

My place within the midwifery 'group' will be explored in greater detail in relation to the following chapter, where the greatest challenge to my identity – just like the interviewees' – has been evident.

Chapter Six: Once a Midwife, Always a Midwife?

“Somebody said to me the other day, ‘If I snapped you in half, there would be ‘midwife’ written all the way through you’” – Susan, LSA MO.

6.1 Introduction

In the previous chapter I examined the path to leadership from the perspective of role identity theory, the focus being on individuals’ narratives in relation to the constant interplay between them as agents and as members of a wider organisational structure. Ideas of salience and commitment to role identity were explored, and a key conclusion was that while midwifery leaders clearly made a transition from clinician to their current role, they saw that transition occurring *within* their core midwife role identity. The mechanism through which they achieved this identity maintenance was an expansion of the role identity of the midwife to include leadership, management, supervision and education, depending on their particular role.

However, social identity theory takes a different perspective on identity, and this chapter deals with the interviewees’ leadership enactment. While interviewees did not appear to sense a conflict in their *role* identity from a self-definition view, maintaining membership of the midwife professional *group* may be a more problematic issue, as identified in the literature review chapters.

In this chapter I look at endogenous and exogenous factors relevant to the transition to and enactment of clinical leadership from a group identity perspective, and lead into the final data chapter, in which I examine the counter-narratives of clinical midwives.

6.2 Clinician or non-clinician?

In this first part of the chapter, I look at the interviewees' narratives in relation to their current role, and in the context of whether they have managed (or wanted) to maintain some element of clinical practice.

6.2.1 Practising Clinically Now?

Five of the interviewees were no longer practising clinically. Of the other four, three managed only sporadic clinical work. Louise described how she generally achieved clinical time:

"They can call me any time, and they do, and I do end up on labour ward. And I may not necessarily go and deliver a baby, but I might go and muck in and clean a room, if it means turning things around".

Only one interviewee, Karen, continued to maintain a regular clinical role. However, in a position supposed to be divided equally between clinical and managerial time, Karen was undertaking just one community clinic per week:

"I've always covered on the rota, either annual leave – once I gave up my caseload - made sure that I'd cover annual leave or sick leave, maternity leave, just to give some continuity to caseloads".

6.2.2 Reduction in Clinical Time

The majority of the interviewees were still working clinically when they were band 7 midwives, and found the move to a ward manager or matron role the point where the balance shifted from clinical to managerial work. However, at managerial level, the role – as described earlier – was supposed to be equally weighted with clinical hours. Louise, as a band 7 ward manager, found this weighting gradually changed:

"It was split 60-40, at that stage, and it was more sort of 60 clinical, 40 management. And then it swapped around, over a little bit more time".

At matron level, things tended to become more complex, as Pauline explained, describing her secondment to a matron role:

"They wanted us to work clinically, but there was too much to do, to work clinically... You couldn't really – couldn't be part of the rota, because of the demands of the service, and the remit I was covering – you couldn't really do a whole shift clinically, it was as and when you could".

Most of the interviewees would like to have some clinical time allocated within their current role:

"I don't give true, hands on care. Part of me would like to – I do miss some elements of it. Seeing the mother's face when she's birthed her baby, there is something out of this world in that" – Natalie, LME.

Caroline felt particularly strongly on this issue, being disconcerted by her lack of clinical time, and discussed her intention to return to practice, along with her rationale for doing so:

"I'm still staying within the role, but I'm going to make it – because it has bothered me over the last few years, that I used to be on top of my midwifery practice, and could have practised anywhere. And being out of practice for two years is – is not, for me personally, is not good and doesn't sit well with me... I want to do it for me. I need to do it for me, to feel that I'm fulfilling the role that I'm in".

Caroline was particularly clear in relating her desire to practise clinically, which may be linked to her role as PDM. Previously, she expressed pride in being the first PDM in her Trust, and valued the opportunity to work alongside new starters.

An alternative view was expressed by Pauline, who did not have any regrets or sense of loss on moving away from clinical work:

“What am I missing? Because at the end of the day, 18 years in the community, which I loved to bits – I’ve done it. I’ve, you know, I’ve – you could say, you’ve worn the t-shirt. I’ve moved on now. You know, next – the next chapter of the book is where I’m at. When you’ve read a story, you don’t keep going back to that story, you look for another, you know – what’s coming next? No, I don’t miss the – the daily clinical hands-on antenatal delivery – I’ve done all that”.

Several of the interviewees discussed their emotions on leaving clinical practice. Natalie described this in terms of loss:

“Going into education, I grieved for practice for a good few years. Occasionally I still do”.

The main challenge for those wishing to maintain a clinical element to their current role appeared to be related to time:

“I do have days when I think, you know, it would be really nice to go out and get some hands on... but I think it’s the usual challenge of time and resources” – Deborah, matron.

Susan, while acknowledging a desire to work clinically, appeared well-placed to see the issue from both sides:

“I mean, I have to say, I would love to spend time in clinical midwifery. I came out of management to go back into clinical practice, but then I moved out of clinical practice into management because I felt there were things that were being done that actually I felt should be done in a different way”.

6.2.3 ‘Being’ a Leader

Key themes that emerged in an exploration of what it meant to lead clinical staff were empathy, communication, and leading by example.

Deborah described the challenge of empathising with clinical staff but also having to line manage them and spoke of a recent incident in which a member of staff had sent an email detailing why a particular piece of work had not been done, and had stressed such issues as staff sickness:

“I thought, ‘Well, you know, I appreciate what you’re saying, but I can’t go there, because at the end of the day we still have to move the service forward’. And then I went to seek her out and had a little chat with her about her frustrations, and it’s about – having that skill to actually acknowledge, but say, ‘I acknowledge what you’re saying to me, I acknowledge that there are difficulties. However, we need to think about how we can overcome that’. If we sit and dwell on all the negativity, we’re not going to get anywhere”.

Karen saw the value of empathy as a means of engaging clinical staff, and then encouraging them to see another possible vision:

“If you can explain what your reasonings are around – or how you’ve come to that decision, or what the background is, and whilst you listen to what they’ve got to say, and you can sort of, ‘Yeah, I agree with that, however if you look at it from this angle’, then you can get people to sort of – not completely change, but bend”.

Communication was seen as a key element of the clinical leadership role, for example through involving staff in planning:

“I had an experience a couple of years ago, where I wanted to develop service, and at the time I was very enthusiastic about it, and I went charging off doing this, this, and this, but didn’t acknowledge that if you don’t push the right buttons and speak to the right stakeholders, it can undo weeks and weeks of (laughing) – in five minutes. So again, that’s taught me, if I want to lead something forward, to really think about the process first, and think about all the possible fallout and, you know, make sure that you are involving the key people” – Deborah, matron.

Natalie described the importance of direct communication for problems to be raised, but also mentioned the challenge of empathy and engagement, in relation to her communication with clinical staff from an LME perspective:

“Most of them are very receptive. Because if I see they’re busy, I say, ‘Hi, nice to see you, I can see you’re busy. Unless there’s anything urgent, I’m going’. And normally it’s – and that’s fine, because that’s the job. You know, if I go in and say, ‘I’m sorry, I need half an hour of your time now’, and I can see they are heaving, what recognition – how on earth am I being supportive of them? I’m not. That’s not appropriate”.

Interviewees clearly attached a great deal of importance to staff engagement and buy-in:

“It goes hand in hand. If you’ve got a happy workforce, they’re going to give their best... I think, going back to basics, just valuing your staff. If you value them – [BD: And showing them?] Yes, showing them that they’re valued, and you’ve got the respect for them. That alone will bring a happy workforce” – Pauline, matron.

The third key element in leading clinical colleagues was described in terms of leading by example. Louise described this as central to her understanding of leadership:

“Well, that’s what the role was about, to me, and it always has been. Because if people see you doing things in a certain way, they’ll think that that’s acceptable, especially if you’re one of their peers. So I’ve always thought that was really sort of key”.

Heather was able to neatly sum up the relationship between empathy, engagement and leading by example:

“If you show – you know, I think I brought that up in my last interview, about having these core, basic values, you know, that are very dear to me. Treating people with kindness and respect... So – and when you have that, and I think you can demonstrate that in what you – as well as trying to change, you know, and dealing with difficult situations, but you can do it in an empathetic way. I think you engage people far more effectively, yeah”.

6.2.4 Benefits and Challenges of a Non-clinical Role

Interviewees were able to identify both benefits and disadvantages to a non-clinical managerial role. One of the principal benefits of not working clinically alongside a leadership or managerial role was expressed by Lesley, talking about ways to resolve the desire to take a hands-on approach:

“My instinct [when the unit is busy] is to want to go out and jump in and help them, but that intervention will only last half an hour, maybe an hour, and it will benefit only one or two people that I’ve managed to help out in there”.

Lesley went on to compare this with the benefits of her matron role:

“The work I’m doing in here, hopefully will have a much greater utilitarian sort of, you know – a much wider reaching benefit. So that’s how you’ve got to think about it”.

Similarly, Susan was able to think on a larger scale when weighing up the costs and benefits of a non-clinical role:

“You have to give up some of that, that you hold really dear to you, to be able to manage the service. But in doing so, you move from providing safe care for about 30 whole time equivalent women a year, to 3000, or however many thousands that are in your care”.

Several of the interviewees described a sense of clarity associated with a move away from clinical practice on taking on leadership roles:

“You then become more exposed to the higher levels [in a team leader position], and you start to see how the Trust functions. And I think when you’re working purely clinically, very often that does go over your head, because you’re so absorbed in your... with your day to day work, with your caseload, you’re seeing things from a different perspective” – Deborah, matron.

While the interviewees were able to see benefits to a reduction or cessation in their clinical role, they also identified problems associated with this change. Natalie, who has been away from clinical practice for the longest time, spoke about a reduction in communication with the clinical area, and its consequences:

“I think I lost some confidence, because if you’re not dealing with the multi-disciplinary team, particularly senior people, on a regular basis, you don’t have the same dialogue with them”.

There appeared to be a sense of disappointment in not achieving clinical time, evident in most of the interviewees' narratives, albeit tempered by the idea that they are doing midwifery on a larger scale in their current roles. Of most interest is the fact that almost all the interviewees – with the notable exception of Pauline – would like to spend some of their time in the clinical area. This theme will be examined from the perspective of group membership later in the chapter.

6.3 Credibility

As noted in the literature review around clinical leadership, credibility is a key issue in maintaining a professional identity. Credibility can be described in terms of the interviewees as individuals, as well as in relation to professional group membership and the perception of others. This section of the chapter addresses ways in which the interviewees spoke about their professional credibility, from individual, inter-group and intra-group perspectives.

6.3.1 A Clinical Background

The interviewees described how their years as clinical midwives were the root of their credibility with clinicians:

“I think the fact that I have worked in many, many areas in midwifery has always underpinned my credibility and underpinned my confidence in my own abilities. So I feel – I might be slightly out of speed on different areas, but I’ve definitely had an orientation to it. I’ve been there, I’ve been there, so I can talk, hopefully informatively, about most areas of midwifery practice” – Lesley, matron.

However, they were also acutely aware that there might be a perception among clinicians that service leaders are removed from the real problems within clinical life:

“And I think the issue as well is that there is this attitude as well, that if you want to go into a leadership programme, that you are moving away from that clinical area... That ‘you can’t possibly know what’s going off, because you sit in an office all day. You don’t contact people on a day to day basis’. And that is one of the key things that I focus on, because I don’t ever want to be put in a position or challenged about not knowing what’s actually happening” – Deborah, matron.

6.3.2 Maintaining Credibility

As expected, given that the interviewees self-defined as midwives, they gave many examples within a midwifery sphere through which they maintained their clinical credibility:

“I don’t get to go down to the postnatal-antenatal ward as much as I would like, but I do. And also, I think because I’m still an ALSO instructor, I’m still in there, teaching skills, and I teach on the skills and drills [mandatory midwifery update days]” – Lesley, matron.

Karen, as the only interviewee with a continued regular (albeit minimal) clinical caseload, described the rationale for undertaking this part of her role in terms of credibility with clinical colleagues and the women in her care:

“Yeah, we do know the service, we know how it works, we know where the shortfalls are, but we know where the good bits are”.

Pauline believed the problem with credibility for clinical leaders lies in the comprehension among frontline staff of midwifery as only a hands-on activity:

“I think it’s understanding your role as a midwife per se, if you like, because at the end of the day, it’s – it’s how they see themselves, how they see midwifery. Do they

see midwifery as hands-on, doing their clinical aspects? Do they not see the management of the service that we provide as midwifery? Do they not see that the systems and processes we put in place all affects the care that we give, all affects the quality that we give?”

6.3.3 Inter-group Comparisons

As social identity theory would suggest, the interviewees extolled their midwifery group membership through comparison of their skills and abilities with another group: in this case, non-clinical NHS managers. The difference lay in their ability to work as a clinical midwife if required to – they might be rusty, but they could still do the job:

“If a situation arose, I would still go out there as a midwife – you know, because don’t forget, you have some managers who have no nursing and no midwife input at all, so therefore, then, they are managers and that’s all they can do. They couldn’t go out there and roll up their sleeves and – whereas we can” – Pauline, matron.

The question of clinical and non-clinical leadership was raised by Deborah, who was able to see the benefits of both types of leader:

“One of the worst things is, when we started bringing in external managers into the NHS, you can see straight away then, there are gaps, because obviously they don’t have any clinical element to their role. But they’re very good with their analytical skills and, you know, their project management, and one thing and another. So it’s about blending... the two together”.

While non-clinical leaders were valued for their particular skills, Susan pointed out the significance of leadership at the clinical level:

“I don’t have a problem with somebody coming in from Marks and Spencer at chief executive level, because it’s a skill that – that’s honed, then, to just pure management that you need at the level. Fine. But actually, once you start getting down at – at the further layer, you have to have an understanding, so that you can actually work out how that’s going to happen”.

6.3.4 Maintenance of Professional Group Membership

While continuing some degree of clinical time was seen as an ideal way to maintain credibility with frontline practitioners, it was not without its problems. Principally, interviewees found that when they tried to take a clinical role, clinicians tended to treat them as line managers:

“People see you there, and they’ll collar you for – ‘I need to discuss this with you’, ‘I need to discuss that with you’, or you get a phone call, you get – and you’re pulled out all the time. So you find you spend your whole time apologising to the woman you’re caring for, because you’re going backwards and forwards and someone’s after you and interrupting all the time. And to me, that makes it more uncomfortable, because I’d much rather be able to spend the time with the women I’m caring for, to be able to go through that uninterrupted, so that they get my time and appropriate care” – Louise, matron.

I asked Heather whether she believed frontline staff saw her as a midwife or as a manager when she tried to work in the clinical area:

“They see me as a manager dipping into midwifery, I think (laughing)... Yeah, you know, and I’ll often be looking after somebody, and I’ll get a phone call from the head of midwifery, or one of the consultants from clinic, and I’ll have to come out of caring for somebody to answer the phone to deal with, you know – it could

sometimes be just a five minute phone call, and then I'm back, or – or members of staff will stop me in the corridor and say, 'Can I come in and see you? Can I make an appointment to see you?'

Given the problematic nature of achieving the status of 'just a midwife', the main mechanism through which the interviewees attempted to demonstrate their continued group membership was visibility. This was a significant theme in almost all the narratives, with visibility taking a variety of forms. For some interviewees, visibility was achieved through 'walking the floor':

"I think you need to be visible, people need to know where you are, get used to seeing you around and about, and – and when you are visible and walking about, that you have got time for everybody, whether it is the housekeeper or whether it's the porter... I think – and then yeah, they know who you are, they're used to seeing you in the – They don't think, 'My God, what's she here for? Why is she walking through the unit?' Or, 'There must be something wrong, because she's here'. Because you are part and parcel of that, you know" – Karen, matron.

The other common way interviewees achieved visibility was through an 'open door' policy, although this was not without its challenges:

"And when I'm here, I have my door open all the time, so midwives, when they're on a shift, they want to see me – 'Can I have two minutes?' It's so easy for them to access me" – Heather, matron.

The interviewees were able to identify a number of reasons as to why visibility was important, which generally related to credibility. Several voiced the idea that visibility enabled staff to express concerns and to know that leaders do see the problems in clinical life:

“And being me, being in my clinical area, I can see what’s going on every day, and so when anything comes up in the management realm, to do with the service that we provide, I’m visible, hands on, I can see what’s going on, and you have a different concept to feed back to them” – Pauline, matron.

The potential to defuse difficult situations was also seen as a benefit of clinical visibility:

“There are days when I know I’m going to walk the floor and I’m going to get an ear bashing. There are days, but I can’t put it off, I have to do it, because it’s better to do it and try and... defuse. It’s better to face it, defuse it, get on with it” – Lesley, matron.

Communication and interaction were key points in clinical visibility for the interviewees, particularly in relation to helping clinicians see them as more than ‘just’ a manager:

“Some will see me as a midwife, because when – they often refer to sort of the senior management team, and often really, we’re kind of classed in that senior management team, when they’re sort of criticising. But, ‘I’m part of that team. Is that what you think I’m like?’ And they’re like, ‘No, no, you’re here all the time, you’re kind of one of us’” – Louise, matron.

The idea of visibility as a means of emphasising their continued midwife group membership was raised consistently throughout the interviews, and appeared to be a theme interviewees had reflected upon at length, particularly in relation to a fear of being seen as purely managers. As described above, interviewees believed they should demonstrate awareness of clinical issues, and also believed visibility meant they were more likely to be seen as ‘one of us’ rather than ‘one of them’. Heather sympathised with the view of clinicians that she should be visible and accessible, describing her disquiet at being moved from the clinical area to the management corridor:

“It didn’t go down well. And I can understand it, you know. I feel like – I feel like I’ll just be another manager – you know, soulless manager, really”.

Empathy with clinical staff’s views of managers was also expressed by Louise:

“A lot of the criticisms you hear of sort of the senior team is that they don’t understand. They can’t possibly understand, because they don’t see the fire-fighting that may happen, or what it’s like when it’s a stressful, busy day. And so therefore, you can’t possibly understand it. And that’s heavily sort of criticised”.

The issue of visibility appears closely linked to the theme of communication according to a midwife identity, raised in the previous chapter. Interviewees believed their visibility was key to identification with the professional group, and were able to rationalise this in a number of ways, with the conclusion that they felt able to justify their identity as ‘one of us’ (midwife) rather than ‘one of them’ (manager).

6.4 Troublesome Areas

So far, we have seen a clear identification with the interviewees’ professional group identity, in which they justified a continued membership through emphasising their clinical credibility, making inter-group comparisons with non-clinician leaders and managers. However, there were also significant themes which demonstrated a more complex picture, hinted at in issues of credibility, and described in greater detail in the next sections.

6.4.1 Offices and Uniforms

The majority of the interviewees’ offices were located away from the clinical area, with only two interviewees situated within or just outside a ward. Heather was moved (not by her own choice) to the hospital’s management corridor between the two interviews, and given her already conflicted view of whether a clinical leadership role was right for her, it is

perhaps unsurprising that she found the move a difficult one. As described above, Heather was concerned about becoming “just another manager”, and in the second interview it appeared her fears were confirmed:

“I find that, as a – as a manager, as a leader, I can’t lead my team because I’m not there. I’m not present to lead them”.

On a general level, interviewees were able to identify benefits and disadvantages to being situated away from the clinical area. At the first interview, in advance of her move, Heather was anticipating fewer interruptions to the working day:

“It’s so easy for them to access me. You might say, actually, I’m too accessible, because I struggle getting all my work done, some days, because it’s constant interruptions all day. What it will do, going into [the management corridor] – the good thing is, it’ll stop all the interruptions, it’ll actually free up a day each week for me to work a shift, so I’ll be down here [on labour suite] for a shift”.

The other advantage to being situated in the management corridor, expressed by Louise, related to a feeling of being better supported by and more ‘part of’ the management team:

“But it’s nice where I kind of have as well, because all the senior midwives are together, and matrons, so if you’re struggling with something, you’ve got somebody to kind of bat ideas off, and so you’re not quite so isolated with just, this is the area that I work in”.

Heather, after the move, expressed a similar opinion:

“I could see the benefits of me moving up here. I think as a matron, you know, as a manager of the maternity unit, I felt that yes, I had to have that strategic input, and I wanted that, and I did feel left out of the loop at times, when I knew that, you

know, the other community matron was up here, the head of midwifery and the consultants, and things were being decided. And sometimes I wasn't being involved. And that's completely changed. I'm now making – you know, helping make those decisions”.

Heather and Louise were particularly reflective on the issue of site of office, which perhaps related to the fact that they had both been moved away from the clinical area in the recent past. They were able to articulate benefits and disadvantages to wherever an office might be situated. However, while interviewees were able to identify benefits of being situated among leadership and managerial staff, there were significant disadvantages associated with an office away from the clinical area.

First, there was a clear link with the issue of visibility. Being away from the clinical area was considered problematic in terms of awareness of day to day concerns as they happened:

*“If I was in an office in a corridor, you can't relate to it the same, you just can't” –
Pauline, matron.*

Furthermore, Pauline believed there would be a reduced ability for staff to communicate concerns directly to her:

*“Because I can go out there, and they'll say, ‘Oh, look, we've got an hour's waiting time’, you know, ‘so and so's running late’. And I'll say, ‘Well, why's that, then?’
You know – Now, if I wasn't here, I wouldn't know – all I would hear is that that clinic's always an hour late”.*

These issues appeared to be linked to the interviewees' fear that they were perceived as 'just a manager', or 'one of them', if their office were situated in an area considered more managerial than clinical. Louise was aware of the perception that managers just sit behind

a closed door, and spoke of a feeling of detachment since having been moved away from the clinical area:

"It feels a bit more detached... and I think not being seen on a daily basis, even if I wasn't necessarily going to do clinical work, you'd run into much more staff – so you hear a little bit more of, 'Oh, we've not seen you in a long time', in some areas".

Heather reflected in detail after her move from clinical area to management corridor, on the subject of staff perceptions and her own emotions:

"But they miss me, as their matron on – being as accessible as I used to be, and I do feel very, very torn".

The site of offices is an interesting theme for two reasons. First, there seems a conflict of emotions at an individual level among the interviewees: while they were keen to be near the clinical area, they also expressed frustration at struggling to achieve administrative and managerial tasks due to interruptions, and described feeling distanced from senior leaders' decision-making processes. This suggests an awareness of their hybrid identity, and the inherent challenge in spanning the boundary between practitioners and service leaders and managers.

Second, the interviewees were acutely aware, at group level, of the perception held by clinicians, of clinical leaders as 'one of the management', if they were not accessible to the frontline staff on a daily basis. So, while the interviewees might describe themselves as midwives, they were also aware that structural and organisational imperatives might have the potential to block this self-description being understood and validated by their clinical colleagues.

A further example of this conflict is exemplified in the issue of uniform wearing. I noticed that the interviewees based in a hospital setting (the matrons) wore either uniform or

smart mufti, and in fact several wore uniform during one interview and mufti during the other. Again, this theme can be explored at individual and group levels.

At the individual level, interviewees explained that they made clothing choices according to what they were doing on any given day:

"I do believe in visibility, so I do very often wear my uniform, unless I'm doing things like interviewing, because I think it – sometimes it's a little bit intimidating. Or if I'm going out of the – if I know I'm going out of the unit to engage with other agencies and – then sometimes you do look a bit of a lemon, sat there in a clinical uniform when they're all sat there in their civvies" – Deborah, matron.

Pauline saw uniform as a representation of her clinical role:

"I haven't got a problem with uniform, if that's what they want us to be in, because they want us to be clinical as well as managerial. It's fine by me, and as I said, sometimes you don't know what circumstances could happen each day".

The wearing of uniform can also be explored at the group level. Heather described having begun wearing uniform more regularly due to staff preferences:

"I rarely wear uniform, but I have started wearing uniform for the past month, I do put it on once or twice a week... Uniform day today (laughing)! Because the staff really like to see me in uniform, you know, because it... One of the senior midwives said, 'We feel reassured, you're a reassuring presence when we see you in uniform... And I think, well, if it's important to them. They say that it almost feel like 'We have our safety net, we have somebody that we feel cares and knows, and is there looking out for us and supporting us'".

However, Heather's rationale for wearing uniform also concerned her self-identification:

"I went down [to labour suite] this morning, and I'm not in uniform today, as you see, and I feel a bit, yeah, you know, I should... [BD: Manager-ish? (both laughing) Today I'm a manager] Yeah (laughing)".

Uniform Stories

When I was doing a Masters in Research Methods, I spent some time involved in evaluating a shift pattern change in the unit where I worked. I managed to negotiate 'protected time', as there was a great deal of data collection involved in the evaluation, and when I was working under this protected time, I would go into the hospital wearing mufti. Invariably, I used to get comments from my clinical colleagues: 'Oh, not working today then?' Or, 'Hope you've got your uniform in your bag, we're busy today and we might need you to help out'. The implication was that I was not doing 'proper' work, but I could be called upon to do so at any moment. I spent a lot of time secreted away in the ward seminar room...

Recently, a midwife friend has been covering sick leave for one of the matrons. The issue of uniform has loomed large for her, as she is usually working at band 6 – for this role, she has been a band 7 (although her salary did not reflect this for the first several months. But that's another story...). She described how different she felt, and how differently she was treated, once she gained the uniform of a matron, several months into the job. She felt more confident when attending trust meetings and matron forums, and she felt people took her more seriously. Very recently, she has gone back to her band 6 role, and the uniform accordingly. As she puts it, the weight of expectation has gone from her shoulders.

One further story comes to mind: when I arrived at one of the units I worked in, there was a change of uniform underway. It appeared there was some difficulty involved, as the band 7 labour suite midwives (coordinators of individual shifts) were supposed to now have the same uniform as the band 5s and 6s. They refused, and eventually got the same colour uniform as the band 7 ward managers. But I remember the band 6s mocking this refusal, and there was an ongoing tension between the band 7s and the rest of the clinicians for some time afterwards.

On the surface, it would seem such a small thing, the wearing of uniform, but it is clearly significant to many people. Perhaps it might be described as an embodiment of who you 'are' in the clinical setting. It's certainly a useful way of exploring our own and others' perceptions of an identity, and an example of potential conflict at individual and group levels.

6.4.2 Leaving the Gang

Leaving the Band 6 Gang

While I was undertaking the service evaluation I mentioned earlier, I remember beginning to sense a separation from my clinical colleagues to some degree. First, because I was asked by the HoM to undertake the work, I felt I had been singled out as having something extra to offer, particularly as I was given protected time in which to do the evaluation. I also had more interaction with the HoM, matron and ward managers, and started to understand more of the managerial hierarchy in the unit. Second, I had interactions with the mysterious people from Human Resources, who I barely knew existed before then. And finally, looking at the maternity workforce from the outside in, I began to gain a quite different perspective on, for example, the influence of the band 7s on labour suite, and the divisions between the various clinical areas – all things I had been exposed to before, but I now had the tools to explore the reasons for these tensions.

But like the interviewees, there was a lot of discomfort in that separation. I liked my gang – I liked my clinical midwife identity. However, I also knew that it would be problematic to undertake the kind of research I wanted to do, while remaining a clinician.

When I went on to get the PhD studentship, I knew the separation was complete. People often ask me whether I'll go back to clinical work, but I have to say it's unlikely. A band 6 midwife with a PhD? Unheard of. For the simple reason that at band 6, you have little control over trust events, and I'd be as frustrated as I ever was, within about 10 minutes of arriving back in the clinical area.

The majority of the interviewees had experienced the transition from practitioner to clinical leader within the same unit they had already been working in, and they recognised the challenges inherent in leading and managing colleagues and friends:

"It was a bit home from home, really, which in a way is difficult, because you have to really affirm your presence as, you know, 'I'm not your friend, but I am friendly', and actually, earn your stripes and their respect... [But] I didn't have a problem at all with that. I don't have a very high desire to be liked, or should I say, a need to be liked" – Lesley, matron.

In leading and managing the team of which they had been a member, the interviewees were again aware of the impact of others' perceptions:

"There was a lot of hostility at the start, when they see somebody's working supernumerary, that doesn't take on a caseload of women. For colleagues who were very – I thought would have been very supportive – were not at all. And I don't know why – I don't understand why somebody can go from being very supportive to you, as a colleague and as a fellow worker, nurse, midwife, whatever – then, as soon as they see you in another role, they change towards you... And that was hard to work through, because I wasn't prepared for that. But – and there's still, to this day, you know – I cope with it and deal with it now, but at the start it was very – it was – it wasn't nice" – Caroline, PDM.

Several interviewees described a necessary change in relationships:

"And it's funny, because in our team meetings, with the senior midwives that I lead, it's funny because I think the first couple of meetings, they were very defensive, and I felt that there was a lot of defensive behaviour in the room... Because I was challenging them, I was asking them, I was questioning" – Lesley, matron.

Susan believed the idea of being a friend to no-one but leader of all meant it might be easier to go to a new unit when taking up a leadership role:

"That's one thing I think is really challenging. If you grow up in a unit, with all your friends, I think it's much more challenging – I'm not saying it's not possible, but I find it easier not to be. So it makes the position more lonely, even though you know you're supported by your staff... And it's – but it's a minefield, if you're friends" – Susan, LSA MO.

Pauline suggested that band 7s struggle with the necessary separation entailed within the role, perhaps reacting by hanging onto their clinical identity:

“Maybe at the band 7 level that’s what they’re struggling with, is having to do that. They still want to be one of the team, so they kind of hang onto that clinical identity, and miss the fact that actually, they’re very valuable at the level that they’re at”.

The idea of ‘leaving the gang’ goes back to the theme, expressed in the previous chapter, that interviewees have had to give up some part of what they hold dear in order to achieve more. There is also a relationship to the turmoil seen with regard to the site of offices: interviewees wanted to be close to the clinical area (in all senses), but were aware of the benefits of distancing themselves to some degree.

6.4.3 A Rock and a Hard Place

As described earlier in this chapter, interviewees were able to identify key behaviours at the individual level to encourage effective leadership, namely empathy, communication, and leading by example. However, at the group level they were aware that clinicians’ perceptions of them might inhibit their effectiveness as leaders.

When asked about clinical midwives’ perceptions of them, interviewees suggested that clinicians tend to label anyone in a formal leadership role as ‘management’:

“And the trouble is, management is always seen by clinicians in a manager – a negative light. They’re the ones that... ‘They’re the ones who won’t let us do things’, yeah” – Susan, LSA MO.

Like Karen, other interviewees contrasted the perception of clinicians with their own self-identification:

"I don't think everyone perceives me as a midwife, because I have had – for example, we do the ward assurance audits, where we have to go into another area. So I currently have cancer and rehab ward that I visit on a monthly basis... And I talk to staff up there, and they'll say, 'Oh, you're a midwife. But you're a matron, so you don't deliver babies any more'. And I say, well, no, I don't actually get my hands on, delivering babies any more, but I support staff that are, you know, hands on, I actually do get involved in a lot of antenatal work, dealing with issues with women, so I do have to have that grounding, I do have to understand what is expected of a midwife during that actual antenatal period, and the postnatal – because I pick up all the community stuff. So I think... sometimes they do struggle in thinking that all I'm doing is filling forms in and reading emails" – Deborah, matron.

The interviewees believed staff perceptions were generally, at an individual level, based on their experiences. For example, Lesley spoke about the perception of clinicians she had taught during her years as a midwifery lecturer:

"I think the band 6s are far more likely to see me as a midwife than the band 7s... Because an awful lot of them would know – have known me as a midwife teacher. And I – I like to kind of sit, and wander around, and chat to them".

Pauline hoped she would be thought of as both leader and manager, but with important and valuable clinical knowledge:

"They see you as a manager with knowledge, so they would see you as – as [laughing] – whether they're right or wrong – because you're at this level – they think that you've got a wealth of knowledge, do you know what I mean? You've gone through the practical side of things and so you – you've gained all those skills on your way to get to where I'm at, so 'Pauline knows everything' (laughing). Well,

that's what I'm saying, that's how – or, 'Go to Pauline, because Pauline will know that, Pauline will know that', and that's fine. So they see you as a manager and a leader, but they also think you've got a wealth of knowledge and expertise" – Pauline, matron.

While the interviewees were not comfortable with the idea of being perceived as managers, they were able to sympathise with this view, and offered various reasons why it might happen. Deborah reflected on a clinician view of HoMs as managers:

"I can see why they do think that... I think it's difficult because the head of midwifery role is not standardised across the whole country, and there is... There is this tendency, now, to lump it in with the general manager, lead nurse, general-covers-everything role... And I think that hasn't helped that professional element of it, because it then does become more, you know, pure management role".

Natalie, meanwhile, suggested the importance of socialisation in clinicians forming particular views about leaders and managers:

"What I find so frustrating is, a lot of those midwives [with negative attitudes], I knew as students. And they didn't leave here [behaving like that] – so there's a lot of peer pressure. And I do think peer pressure – having to conform or get out".

The interviewees were unsurprised by the negative attitude attached to being a 'manager'. Pauline believed public perception was a driver in this:

"I am a manager, and I do see myself as a manager, but – but a midwifery manager. But yes, from the public's realm, they see us as a manager".

Susan suggested a negative view might be linked to clinicians' reluctance to move into clinical leadership roles:

“And actually, why would you want to put yourself into that position where actually, you work longer hours than ever, but you’re not paid for them – so the staff on the shop floor take home a heck of a lot more than you”.

In the first data chapter, there was a strong sense of ‘I am still a midwife’ in the interviewees’ narratives, which were analysed from an individualistic perspective. However, when looking at identity maintenance from a group perspective, analysis has shown a far more complex picture. Identity maintenance in this chapter has been closely related to the interviewees’ interaction with fellow midwives, and they appear aware that others’ perception may not be as positive as their own.

‘The Cream of Nursing’

Of all the observational experiences I had during the band 8 leadership programme, I think this one stuck most firmly. The participants were mid-way through a two-day element of the programme, and a session was being presented which involved a former chief executive of an NHS trust. Within the first minute of his presentation, he made two remarks that would elicit huge amounts of conversation at coffee time. First, he commented on the fact that this was the most nerve-wracking presentation he had given, being to a roomful of midwives; he described midwives as ‘daunting’ and ‘intimidating’.

Then, a couple of sentences later, he referred to midwives as ‘the cream of nursing’. I was extremely offended by this title: I had never been a nurse, although I obviously had nursing skills as part of my midwifery role. I also felt it offended nurses – I didn’t think they would appreciate the idea that midwives are somehow ‘better’ than them! I wondered, though, if it was just me that felt his remark was irritating in its lack of understanding – particularly as many of the course participants trained in the days when you had to do nursing prior to midwifery training.

At coffee, all became clear... I was not alone. There was a lively discussion among the participants, and I realised just how many of them had picked up on his remarks. First, they really did not like the idea that they were daunting or intimidating. And second, the idea of being the cream of nursing utterly negated their midwifery identity.

I referred to this observation during the interviews, which is what led to discussions around the NHS perception of midwives in relation to nursing.

6.5 Inter- and intra-professional Issues

The interviewees discussed the perception of midwives from the perspective of the NHS more widely, where it became clear that as well as misperceptions within the profession, they feel there is a lack of understanding from beyond it.

6.5.1 Relationships with Nursing

Interviewees believed there was value to be found in working alongside nurses:

“When you go into that sort of agenda, when it’s more nursing-focused – but at the end of the day you’re all leaders within your own disciplines – it was really good to actually share that experience, because you know – a lot of the things are transferable, but it’s about having the skills to develop and to deal with situations. So it was good to bounce things off people that saw it from a completely different perspective, that weren’t absorbed in all the midwifery elements” – Deborah, matron.

On being appointed practice development matron for midwifery, Caroline was pleased to find nurses with a similar role:

“They were very welcoming, they were more than delighted that I’d come, but I had to find out myself who they were, what they were, what they did – which they were very forthcoming in telling me, which was wonderful. And then they became my support... There’s a lot of work we do together, which is relevant for midwifery, and I’ve educated probably nurses a lot into what – into the way we care for women and babies in midwifery. And vice versa – I’ve taken a lot out of the work that they do, and I feel that – that we work very closely together, which is wonderful”.

However, while nurses and midwives clearly have much to learn from each other, the interviewees believed the professions should be managed differently, and understood as two linked – but not identical – groups:

“Whilst I, you know, I realise that we’re not big enough to be a separate directorate, but to sit under a nurse, who is the director of nursing, who’s got no midwifery background whatsoever, I find it very frustrating to have to explain to him – even what a PPH [postpartum haemorrhage] is” – Karen, matron.

This issue of explaining exactly what midwives ‘are’, if they are not nurses, loomed large, as Susan described the difficulties in articulating exactly what the differences are between nurses and midwives:

“But midwifery is a very different profession to nursing. It’s not better... it’s just different. And it’s understanding those differences, and – and I often ask myself, what are the differences? How do you vocalise that? And I think there’s a whole piece of work to do, to actually really vocalise what the differences are. Without trying to say one’s better than the other, because it’s not... I know very many fantastic nurses who are very sort of committed etcetera, but in – in midwifery – you’re autonomous in both, but in midwifery comes not only autonomy, but the responsibility for the whole care, rather than your aspect of the care. And I think that would probably be – the biggest thing is that you’re totally accountable for everything”.

Heather also addressed the issue of autonomy as a key difference between midwifery and nursing:

“I think, because you know, midwifery is an autonomous role, compared to nursing – and... as direct entry midwives we tend to be more reflective, more questioning,

and I think that's exactly the approach we're taught from day one, and nurses aren't... And nurses aren't. It's more the directive... course that they're given. So – and that's not the same with us”.

The interviewees also suggested that trust boards are treating midwifery as an extension – or even an arm of – nursing:

“It is worrying that they still think that you can just lump everything in [with nursing]. And also, one of the comments that was made [during a service review at the trust] was about... almost suggesting that midwifery is just an extension of nursing, yet again... My struggle here is that – I attend the matron board meetings, and when I attend, I attend as a midwifery matron, and so does [my colleague], and we are very vocal at putting our midwifery point across... So it's about, you know, saying, if you've got an issue in nursing, fine. But we haven't got an issue, so you sort your bit out, but leave ours alone” – Deborah, matron.

They suggested this perception was based on a lack of understanding:

“It's about knowing where midwifery sits on your director of nursing's radar. And it actually does sit very strongly at the moment, but I'm not convinced that her team around her feel the same way, and that's actually, you know – and it's minimising that damage impact really, and knowing how to work with the level of, you know, executive nursing, basically” – Deborah, matron.

Susan suggested that there might be some logic in trust boards not understanding the difference between nursing and midwifery:

“I think too, that because we can't vocalise what the difference is, it makes it very hard, then, at board level, to know why – why it isn't just like theatre nursing, or ITU. You know, [they think] it's a speciality of nursing”.

6.5.2 Relationships within Midwifery

While it might be expected, given midwifery's difficult history, to find evidence of a lack of understanding – or even acknowledgment – of the profession's identity from a wider NHS perspective, there were also intra-group problems apparent. As I described earlier, interviewees were aware of intra-group perceptions of them as 'the management'. However, this appeared to be a two-way street, and various issues between themselves and other bands of midwives emerged. In particular, interviewees held particular views about band 7 labour suite shift coordinators and consultant midwives.

The interviewees identified particular problems associated with the band 7 coordinator role (as differentiated from the band 7 ward manager role). The main theme to emerge was around a perception that band 7s fear 'leaving the gang':

"Once you become a band 7, in that leadership role, you can't run with the pack basically. You've got to have some buffer between yourself and the band 6s, band 5s, because you are going to be expected to deal with difficult situations, with challenging situations, confrontations... You don't belong in that gang any more, and I actually had that said to me by my manager. You've got to learn to be – you know, you won't get the Christmas cards you had before, you won't be invited out to all the team things" – Deborah, matron.

These ideas seemed to strongly echo their own experiences of moving to band 7, as I described earlier in the chapter. Now looking at the band 7 role from a line manager perspective, the interviewees were able to reflect on problems associated with it. The main issue related to the idea that band 7s have only a micro-level view of the service, which Deborah was not entirely sympathetic to:

“I’ll tell you what switches me off – when my band 7s come to me – is when they start whinging. When they start going into all the detail. I don’t want all the detail, tell me what the key issues are – I haven’t got time for the detail. You can have the detail and you can sift it out, then bring to me what your key issues are”.

Heather felt it was important to attempt to change this, by exposing band 7s to managerial perspectives:

“I think as a band 7, you have to step up and take on that managerial responsibility, but it shouldn’t be all-encompassing, I don’t think. I think it should be an element – you are managing the shift for that – you know, the midwives on that shift for that day. But I think, yeah, you should definitely keep a managerial role, maybe have a day, I’m quite supportive of that, coordinators having a day of management each month, and giving them specific roles”.

Band 7 in midwifery incorporates a wide range of roles. Karen saw distinct differences between some roles. While she saw the team leaders and ward managers as positive and well-defined roles, with clear managerial responsibilities, Karen was somewhat ambivalent on the subject of the band 7 shift coordinators:

“Our group of coordinators are very much of a similar age, very much qualified round about the same sort of time, and have probably followed a similar path to get to their band 7 roles. Very different personalities. Overall, a very together group... who sort of support one another in that role”.

Other interviewees expressed concerns about band 7 shift coordinators. Deborah saw them as stuck between a rock and a hard place, but holding more power and influence than they realise:

"I do think the – they have got a lot of power, and I don't think they probably use the influence that they've got, because they are sitting on that – you know, they're in that – they've got the advantage of direct contact with the midwives, listening to their concerns, and listening to the women as well, but also transforming that into the language that the next layer – level – will actually listen to".

Heather had had particular difficulties with band 7 coordinators when she was new in the matron post:

"I came in on the Monday, thinking what on earth do I do? And under my door was this long letter, written by the senior midwives on labour ward, and signed by them all, saying, 'We want you to change this, and do this'... So I sat down... I sat down in here, and I cried my eyes out, because I just thought, I've nobody".

There was recognition among the interviewees of the importance of acknowledging and working with the influential band 7s. Pauline spoke of helping the band 7s to see their own influence, emphasising the importance of clear communication:

"I think it's still down to identifying what their expectations are, and what you expect from them, because if you – if you have that grounding from the word go, then it's something that they know is expected from them, and they have to step up to the mark and deliver".

Band 7 shift coordinators clearly present particular challenges to clinical leaders higher in the leadership and management hierarchy. Similarly, discussion of the consultant midwife role produced equally reflective views.

The Ideal Job

I'm at a band 6/7 programme study day, and over coffee I'm discussing career ideals with a group of band 6 midwives. Given that they're on a leadership development programme, I naively assume that their ideal role would be matron, or head of midwifery. How wrong I am – none of the five midwives I'm chatting with considers either of these roles something they would aim towards. Instead, they all think the consultant midwife role is the ideal. On discussion of this, they suggest that the consultant role is 'real' midwifery, rather than management (that theme again, of managers not being 'proper' midwives!) According to these midwives, the consultant continues to have a clinical identity – even though they might not practise much at all – simply by virtue of not being a line manager to anyone.

I discussed this theme with the interviewees...

When asked about the consultant midwife role, interviewees had differing views, often based on their own exposure to the role. While some had worked in units where there was a consultant midwife, others had had no experience of the role.

Deborah felt that a consultant midwife might be seen as more 'with woman' than a HoM, echoing the views of the midwives in my observation (above):

"I mean the head of midwifery, at the end of the day, has to know her business. She has to know what's happening with the midwives, and I can see why the band 6/7s that you spoke to see the consultant midwife as a – a more favourable role... Well, they see that more as being with woman, don't they? They see it more as – the interface is more direct".

However, Deborah suggested the consultant midwife role is not actually as 'pure' as midwives might think:

"And again, they've started to lump things into that role, as well, so very often they've got something else tagged onto it. And I do know that, you know, one trust, they have consultant midwife slash head of midwifery... And knowing that

individual, actually, who's doing that role, that must be a really difficult role to be – wanting to be there for the women and being vocal and pushing things forward, but then having to then step onto the other side, and into the other camp, of battling it out with... I see them in conflict, yeah. In that particular one where it's lumped together”.

For Lesley, the consultant midwife role does not exert enough control over the service:

“I was asked to apply for a consultant midwife's post twice in the last 6 months, and I've said, 'Absolutely not. Not for me'. Because if you look at my CV, it's crying out for consultant midwife, because I've got the academic, you know, experience, and I've got the protocol... [BD: But it's not for you?] Just not for me. [BD: Why is it not for you?] Because I – I feel I cannot make the changes I want to make. The consultant midwife role, to me, is great for the person who's doing it, but I don't think it has enough teeth. They can't control the budget”.

Caroline felt there is a lack of clarity as to what consultant midwives actually do, with them often setting their own agenda:

“And I think a lot of people have been allowed to do what they want to do, and got paid very – very well for it. And when it – when the role was first introduced, that's probably what I thought – but – probably because of my experience of seeing that role, and probably the person in that role, to me, it's not what I would want to be”.

A different note was struck by Heather, who understood the attraction of a consultant midwife rather than a HoM role:

“I can see exactly why they say that, and I think if I was honest, I think that consultant midwife would be... something that I would find quite attractive. I don't

see it as necessarily the ultimate clinician. I've met some consultant midwives who don't really do any clinical, actually. But nor is it management, either".

This point was voiced during the first interview, at a time when Heather was struggling with her identity and questioning whether a management role was really for her. By the time of the second interview, however, she had a different view, believing that while a consultant midwife role might look good on paper, it could in reality be quite muddled:

"I think it's a well-paid, luxury job. I've yet to come across a consultant midwife who feels really fulfilled in her post, and really feels she's value for money.. [During a secondment] I was working closely with the consultant midwife – I used to go and help her with the clinic, and I didn't feel that as a consultant midwife, she did much at all, or that there was any effect of her being in that clinic".

There is a clear contrast in views of the consultant midwife role from the band 6/7 and clinical leader perspectives. The reasons for this will be explored further in the next chapter, as I examine in greater depth the narratives of the interviewees in counterpoint to a strong counter-narrative which emerged through interaction with the online midwifery forum.

6.6 Conclusions

While the interviewees strongly identified themselves as continued members of the midwifery professional group, offering examples of ways in which they can demonstrate the credibility they believe is central to such an identification, it became clear that there are areas of conflict.

Questions of visibility, offices and uniforms offered a clue to a conflicted identity, both from an individual and a group perspective. As individuals, while acknowledging and espousing a wider role identity as 'midwife', the interviewees described a sense of loss in

moving to a non-clinical role, and experienced a conflict of ideals in acting as leaders and managers across a professional and organisational interface.

As group members, the conflict came into even sharper focus, with the interviewees showing a clear understanding of how their role is seen more as management than as midwifery. The optimists among them hoped clinicians could still see their midwife identity, and all attempted to challenge the view of them as 'just' management, where management is seen as 'one of them'.

In the final data chapter, I address clinical leadership from the other side of the practitioner-leader fence, exploring clinicians' perceptions of leadership roles, and producing a counter-narrative to the interviewees' self-definition as midwives.

Chapter Seven: A View across the Chasm

7.1 Introduction

The two previous data chapters explored interviewees' self-definitions, with their core identity revealed as 'midwife'. The interviewees provided a strong argument for this continued self-definition, and gave numerous examples of ways in which they could justify their midwife identity. In those chapters, I also explored the interviewees' interplay with the wider context – professional group and organisational structures – which was seen in relation to the development and enactment of leadership roles, and in the challenges of maintaining a professional group identity.

I discovered a group of leaders passionate about midwifery, offering a challenge to the dominant narrative I remembered from clinical life – and to which, to a degree, I admit to having subscribed. I was keen to explore this contrast of narratives further, due to the impact it might have on future midwifery leadership. For example, I wondered whether these nine interviewees were somehow unusual? Or in fact, whether I might have been mistaken in the clinical narrative I had constructed as a practitioner myself.

This chapter begins with a reflection based on discussions with a clinical midwife friend, which pre-empted the online forum exploration. Next, themes which arose from the forum interactions are described, and a strong counter-narrative to that of the interviewees is presented, alongside the interviewees' defence. Finally, I offer a somewhat surprising link between narrative and counter-narrative, which perhaps leaves more questions to be answered.

The chapter explores leadership and management from the practitioners' perspective, in order to investigate further the interaction between individual and group in leadership identity construction and enactment. The findings relate to ideas of followership and

group assumptions, demonstrating the power of the group from a social identity perspective, and offering a caveat to the individualistic focus often seen in leadership development and organisational succession planning.

Challenges to my Thinking

I'm involved in a discussion with a midwife (clinician) friend, on the subject of how I've re-thought my earlier preconceptions about why midwives move into leadership and management roles. For a start, my friend disagrees with the use of 'leadership', instead insisting the interviewees are managers. She doesn't see the matrons, ward team leaders or HoMs as leaders, because they hold a clear line management position.

But her main points relate to how and why senior staff become 'managers', and their distance from the 'real' world of frontline clinical work. On the subject of motivation, my friend subscribes to the dominant narrative, in which clinicians become managers because they don't really like clinical work, or because they're the most senior person available, or because their face fits, or because nobody else wanted the job – or even for all of these reasons.

And on the subject of distance, my friend believes that any manager who no longer works clinically cannot really call themselves a midwife. I argue the clinicians' key point: that they are still doing midwifery, just on a bigger scale or in a different arena – but my friend remains cynical. From her perspective, sitting in an office, shuffling paper, going to meetings – these are not midwifery, these are administrative tasks.

We come to an interesting point, when I ask her whether I can call myself a midwife. She believes that yes, of course I am still a midwife. I'm doing midwifery research. But, I argue, I haven't worked clinically for over two years, and I live in a business school – could I move any further from the frontline? According to my friend, I'm different, because clearly the work I'm doing is 'for' midwives, whereas managers work 'against' the profession and align themselves with organisational imperatives instead of midwifery needs.

Although I find that discussion disheartening, it is not the first (nor the last) time I find

myself wondering whether clinical leaders are aware of the strength of anti-management feeling, or in fact whether there are other clinicians who hold a more positive view. It is this thinking that led me to take my findings from the interviewees' narratives to the Midwifery Sanctuary, along with conversations I had about the attractiveness (or lack of it) of 'managerial' roles at the band 6/7 leadership programme.

7.2 A Strong Counter-Narrative

This part of the chapter is a presentation of the comments offered during my interaction with the online forum, the Midwifery Sanctuary. As I described in the methodology chapter, I used the forum as a place to explore a practitioner perspective on the themes arising from the leadership narratives of the LMS interviewees. **Table 7.1** (below) gives more detail of the process from question to thematic analysis, with a presentation of the four questions and two forum searches, and a synopsis of the themes which emerged. In the following sections, I present the five themes constructed from analysis of these answers and searches, which act as a counter-narrative to the interviewees' stories. I offer examples from the forum responses, and I then examine how the interviewees would answer the accusations levelled at them by the Midwifery Sanctuary respondents, their defence based on data presented in the previous two chapters.

Table 7.1 From questions to themes

<p>Q1: Midwifery managers</p> <p>Hi, I have a question that I need help with... I'm a PhD student and former midwife, looking at midwifery leadership, and I'd love to hear fellow midwives' thoughts on this: Can you call yourself a</p>	<ul style="list-style-type: none"> • Motives for going into management • Real work is clinical • Leadership and management are different, and often disconnected • Managers as (credible) clinicians and simultaneously effective managers • Different units, different roles • Lack of uniformity re: clinical work
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midwife if you don't work clinically?	
<p>Q2: Hands up, midwives</p> <p>Hands up if you aspire to become a midwifery manager. For example, are you aiming for a ward manager post, or would you like to become a matron or even a head of midwifery one day? And if not, why not?</p>	<ul style="list-style-type: none"> • Attraction of everything but management • Other roles as responsible/influential/making a difference • Consultant midwife and ward manager roles as less management, more clinical • Managers removed from practice • Attractions of non-clinical roles • Pressures on managers • Contrast with clinical leadership in medicine • Different units, different experiences
<p>Q3: Matrons: what are they?</p> <p>So, in my PhD thesis, I've been talking to matrons, who have very clear ideas about what their identity is. But I'd like to know what you think: when I say 'matron', is your first response 'midwife', 'manager', or 'leader'? Or maybe a combination of all three? A thousand thanks for all the responses so far to my other questions – your opinions are super valuable!</p>	<ul style="list-style-type: none"> • No uniformity of definition • Not leaders • Management role: command and control • Removed from clinical work • Stereotype: 'Carry On' and Hattie Jacques • Bifurcation of management and leadership
Q4: Beautiful midwifery leadership	<ul style="list-style-type: none"> • All managers should remain clinicians • Perceived lack of empathy from managers

<p>So, as I'm sure you know by now, if you've seen my other questions, I'm looking at midwifery leadership for my PhD. The responses I've had have been great, and as a former midwife myself, I can relate to much of what is being said. I have one more question, and as ever, I'll be hugely appreciative of your responses: What can midwifery managers (at all levels of the service) do to earn the respect of midwives? Can you think of anything that would make their role seem more attractive for your own career path? I know, that was two questions – my apologies!</p>	<ul style="list-style-type: none"> • Unattractiveness of management roles • Managers lose touch with reality of clinical areas
<p>Search: Managers</p>	<ul style="list-style-type: none"> • Becoming managers has changed them • Divorced from realities of clinical life • Unaffected by operational difficulties, e.g. staffing • Unattractive career option
<p>Search: Management</p>	<ul style="list-style-type: none"> • Removed from clinical reality • No acknowledgement of necessity for management • Unattractive career option • Negative stereotypes • Command and control view of management roles • Faceless, uncaring, disempowering pen pushers

7.2.1 Rationale for Management

Responses from the forum would suggest the following rationale for a move from clinical practice to leadership and management roles: midwives become managers because they are fed up with the difficulties of clinical work, or sometimes because they are not effective clinicians.

“I can almost guarantee that every midwifery manager at some point said, ‘No, management, never, not for me, no sirree Bob, I like the clinical area etc. etc. etc.’ Then after x time in the clinical area the prospect of regular office hours, no on-call and having a life at the weekends starts to look a lot more appealing” (response to Q2).

The responses offer a stark contrast with the interviewees’ narratives, in which moving into leadership and management roles was the result of a desire to increase their impact on service delivery and to effect change. Most rose through the organisational hierarchy over a long period, and even those who had progressed rapidly had to make deliberate choices about whether to become leaders and managers.

In relation to wanting to escape from shift work, Natalie was alone in expressing relief at this change in her working life when she moved into a lecturer role, and her feeling related very much to an improved social perspective, rather than simply ‘not liking’ clinical work:

“Not having to do shift work was a big thing... And to be able to actually say, ‘Yes, I could go to that weekend’. I mean I do think, sometimes, that is underestimated, the impact it has on midwives”.

The challenges described by the interviewees, in relation to their continued desire to achieve some clinical practice element within their leadership role, offer a further argument against the forum assumptions. As I wrote in the previous chapter, interviewees

were generally keen (with the exception of Pauline) to continue with a clinical element, but struggled to achieve this in the face of managerial expectations and commitments.

7.2.2 A Removal from Clinical Life

The second emergent theme relates to a perception of midwives somehow 'changing' into or 'becoming' managers: becoming a manager changes you into an uncaring, disconnected, unsupportive 'pen pusher'. You become divorced from the realities of clinical life:

"I realise senior managers were once midwives, and I'm pretty sure originally they went into this for the same kind of reasons as myself, however, 'the needs of the service' seem to have turned them into the kind of people who think it acceptable to give no thought whatsoever to midwives and staff as actual human beings instead of numbers to meet the needs of this service" (search, 'managers').

"I think the issue for me is how divorced senior managers seem to be from clinical practice. For the most part they don't work clinically anymore and some haven't worked clinically for a really long time. It is a real barrier to understanding some of the practical, logistical issues (like how long it actually takes to do certain tasks) and perhaps also means they lack empathy with the staff. In short, the general attitude (deserved or undeserved) from the 'ranks' seems to be that they 'don't have a clue'" (response to Q2).

Again, there is a stark contrast with the interviewees' narratives, in which they described themselves as still caring, still connected, and trying to support clinical staff, as exemplified in the section on 'being' a leader. According to the interviewees, their connection with clinical staff is based within a shared history and identity.

Similarly, the interviewees did not see themselves as 'pen pushers'. From their perspective, having an office offered the chance to get the necessary administrative work

done. Being situated within the management corridor meant the midwifery 'voice' could become more audible at strategic and decision-making levels.

As described in the second data chapter, the interviewees showed understanding for accusations from clinicians relating to physical distance from the clinical area, but felt that visibility through 'walking the floor' and regular informal and formal communication with staff meant that the reality of clinical life was well-understood.

7.2.3 A Degree of Sympathy

While forum respondents were generally scathing about the motivation and characteristics of managerial staff, there was evidence of some sympathy for the difficulties of service management, which resulted in the third theme: part of the reason why managers behave as they do is because of the difficulties they face in meeting the needs of the service:

"As a manager you are juggling ethics, politics, business and finance never mind the wellbeing of your staff and the outcomes for women and their families. And you will always be the fall guy when things don't go to plan. Tough job in my opinion..."
(response to Q4).

"I do also think though that these managers who do as you describe use it as a defence mechanism to protect themselves because if they had to feel the weight of all the people underneath them having to cope with that level of stress, they would not be able to deal with it themselves. So they protect themselves by making it 'not that bad'" (search, 'managers').

As described in the first data chapter, interviewees did not believe they were behaving as anything other than midwives. This perception was built around the idea that midwifery includes leadership, management, education, research, etc. The interviewees expressed

frustration with clinicians' attitudes to management issues, which they saw as equally important as clinical practice.

7.2.4 Credibility

The issue of credibility had great relevance, according to forum respondents, eliciting the fourth theme: managers lose their professional credibility if they no longer work clinically. This is because they cease to understand the difficulties of clinical life, and they fail to empathise with frontline staff:

"Sometimes I think it should be enforced that certain management levels come and work a week of shifts doing what they are expecting everyone else to be able to do. I think some folks sit in offices convincing themselves we are all just fantasist whingers who are lazy and we exaggerate how overstretched we are and how dangerously poor the care we are forced to give has become" (search, 'management').

Managers "don't have a clue what the real deal is in 'a day in the life of a real midwife'. If they did they wouldn't write the claptrap they do" (search, 'management').

However, on the subject of whether you could call yourself a midwife without working clinically, there was less of a consensus:

"This is an NMC requirement in order to maintain registration. Would it be possible to hold a senior midwifery post without having current registration?"

"I think there are a number of ways to demonstrate that you are fit to remain on the register as a midwife, not all of that evidence has to be face to face contact with women"

Some confusion was apparent here, as to what the NMC requirements for maintenance of registration are, which is something I encountered (described in an earlier reflection). Some forum respondents understood the idea that the scope of midwifery is broader than hands-on care alone.

However, while respondents might agree in principle with the idea of a non-clinical midwife identity, opinions on what happens when managers do not work clinically were far more negative, as described earlier.

Like the forum respondents, the interviewees felt strongly about their clinical credibility, and gave many examples of how they maintained it – as described in detail in the previous chapter. A further area of interest lies in the forum respondents' assumption that managers are somehow unwilling to undertake clinical practice, which is in direct opposition to the majority of the interviewees' narratives, in which they expressed a desire to spend time working alongside their clinical colleagues. They not only struggled to achieve this in relation to their managerial workload, but also spoke of the difficulties in being accepted as 'just' a midwife by their clinician colleagues when they were working a clinical shift. There were hints of this in the online respondents' views:

"All of ours have worked recently due to busyness – it was amusing to see them making beds!" (response to Q1).

"I asked the HoM to help out as it was another bed-blocked day and she spent the rest of the shift working in a bay for me updating me on progress etc. – I think she was also avoiding doing the end of the month finances! I've also seen band 8s cleaning delivery rooms to help turn them around for the next person (expensive housekeepers, but just as effective!)" (response to Q1).

The interviewees sympathised with and showed empathy for the problems and challenges of frontline clinical life, but their understanding of the wider issues in maternity services (and the NHS more generally) meant they felt themselves well-placed to see things from a variety of perspectives – a point they tried to communicate to both clinical and managerial colleagues.

7.2.5 A Career in Management?

The final theme emerged from questions of possible futures: management is an unattractive career option. If midwives want to effect change and service improvement, then becoming a manager is not the best way. Instead, they should take on a specialist role, or become a consultant midwife. That way, they will remain a clinician, and therefore credible within the profession:

“Personally there could not be any improvement that could tempt me to be a manager” (response to Q4).

“No, I do not aspire to midwifery management, I’m not interested in that side of things. My interests lie more within the quality and teaching area” (response to Q2).

“When I’m a grown up midwife I think that I would love to be in a position of responsibility and means to influence things but probably more in line with being a consultant midwife than a suited and booted manager as I do love the clinical and teaching aspects” (response to Q2).

The interviewees suggested that clinicians’ opinions of leadership and management were based on a narrow, stereotyped view, as described in the previous chapter. This idea was supported through observational data, for instance the ‘Hot Topics, Pens Out’ piece and the discussion with band 6 midwives on the subject of career ideals.

In contrast to the views expressed by forum respondents, the interviewees' views of, for example, the consultant midwife role, suggested a different perspective, in which credibility as a midwife should go beyond the obvious, 'hands-on' view offered by the forum respondents.

A key issue appeared to be exposure to possible roles. As described in the first data chapter, interviewees were often unaware of career possibilities until they were exposed to higher levels within the organisational hierarchy, and so it is perhaps unsurprising to hear the views of forum respondents, if their views of management and leadership have been formed within the context of a purely clinical role.

7.3 A Yawning Chasm or a Converging Narrative?

The five themes emerging from interaction with forum respondents suggest a largely negative view of midwives as clinical leaders and managers. While respondents did show some degree of sympathy for managerial roles, they were generally scathing of those who choose to move from clinical practice into leadership positions.

I return now to the interviewees, and examine whether their narratives are really so far removed from the counter-narratives of the Midwifery Sanctuary respondents. Here, I discuss questions of management and leadership, identification of clinical leaders as managers, and the question of possible futures.

7.3.1 Leadership versus Management

The general picture emerging from the online forum was that management and leadership are two different things:

"I don't think management and leadership are the same. Good midwives are not necessarily either, but may get propelled into these positions. Management is

largely ignored in the NHS. There is not proper investment to make sure managers have management skills. Leadership is something quite different. To me it implies something almost inspirational. This is not necessarily a requirement for managers” (response to Q1).

This was also a point of discussion during the LMS interviews. Several interviewees identified characteristics associated with leadership, but balanced this with the idea that leadership and management are closely linked. Pauline discussed this in relation to the band 7 role:

“Because even though they’re a manager for their little remit, because they’re operational, they still need to have a leadership role in that, because it’s the leaders – it’s how you lead your team. And management and leadership goes hand in hand, you can’t separate the two... I think it’s the understanding of what you have to do as a manager, but what is required as a leader, because you – to be a leader, you still need to be able to manage, and to manage you still need leadership”.

Karen suggested leadership roles do not necessarily have to be formalised through management positions:

“I think leadership and management are different. I think that you don’t have to be a manager to be a leader, but I think that you can be a leader and be a manager. So I think you can link the two, but I – I feel that... As I say, you don’t have to be a manager to be a leader, and I feel that there’s opportunities within the NHS to work in that – that leadership type role, and not have a managerial role as such”.

Louise felt there was some confusion between leadership and management:

“I think they do get confused, regularly... I think they’re two parts of the same thing, but with very different elements in each one”.

Deborah conceptualised these different elements in relation to clinical and managerial leadership, when talking about how she communicated management issues with clinicians:

“It’s about getting the balance – because you can’t do one in isolation to the other, I don’t feel, because at the end of the day, everybody’s got some responsibility within what – what it is you’re being asked to deliver or develop, or whatever, and – I suppose really, it – If you’re just looking at leadership on its own, apart from a particular role, then again, that’s about the individual and the style, and the way they get people on board. But – I don’t know, there’s always got to be something about somebody that actually makes them want to take something forward, and I mean it’s just that I’m obviously in a role where I do manage teams as well, so I don’t struggle with it... I think it’s about the style, and the way you’re communicating it”.

In relation to self-definition, there was some variation between how interviewees saw themselves. For some, they were leaders *rather than* managers. For Lesley, this was made possible by her relationship with the band 7 midwives:

“I don’t really have to manage them. I have to lead them sometimes, and debrief them, and support them, and guide them, and tell them what I think. I think they respect my opinion. They seem to have respected my opinion, we’ve kind of come to a conclusion together, but they – they don’t need – they very rarely need management. You’re not managing... Maybe that’s because they’re – they’re a good, strong team. If they weren’t a good, strong team I would have to manage them, I guess”.

For others, their self-description was as leader *and* manager:

“I would definitely say I’m both. I manage a team, so I do the things like sort out the annual leave, the PDRs [performance development reviews], whatever, and again, if they’ve got issues they come and share them with me. But I also lead, in that I hopefully am a positive role model for the students, and I do go out and get contracts, I do inspire change” – Natalie, LME.

Heather provided an interesting perspective here. In the first interview, she defined herself as a leader *rather than* a manager, based on her relationship with clinicians:

“I would say I’m a leader. I do like the thought that I am a leader, and that – because I always think a leader is somebody that you would follow, that you would – follow their instructions, or you would – if you say, we’re going to change, we’re going to do this now – that people will do it. And what I found is that when I’ve developed things, or I’ve started new – we’ve done so much work since I’ve been here, about – and we’ve changed so many things – and the midwives have followed. And that’s what I think the basics of being the leader is... [Whereas] a manager’s somebody who is there to ensure that everything is – is being followed, and is being – and to – actually being accountable, and making people accountable for their actions”.

However, by the second interview, Helen had accepted her identity as leader *and* manager:

“But I do see, you know, there is a big managerial element to my job, a very big one. There’s also a big leadership part as well, actually”.

I asked Heather how she felt about this combination, alongside her midwife identity:

“Well, I don’t mind so much as a leader, because I’m a leader of midwifery, so I still feel there’s that element. Manager is maybe a little bit more uncomfortable – I

don't know. I accept that in my role I am everything. I'm a – I'm a three-in-one, yeah (laughing)".

While the interviewees felt able to incorporate leadership and management into their midwifery identity, they were aware of perceptions from the outside:

"I think the trouble is, leadership is seen as management, not as something that can be supportive in any role" – Natalie, LME.

Heather echoed this perception, but wondered whether it might be linked to a lack of understanding:

"I think they see it as very much a joint thing. I'm not sure they really, a lot of people, are able to separate that out, unless – I think the senior midwives can see that, but I think if you're going to ask midwives, you know, band 6 midwives, I think they'd – I don't think they'd probably separate. So if you were to say, 'Is Heather a manager? Or is she a leader?' I think they'd say, 'Well, she's... She's management. She's a manager".

The idea of perceptions of leadership and management was something I raised with forum participants, in the third question, relating to how they saw the matron role. There was a clear perception of matrons as managers:

"Matrons – scary boss. Tend to manage – occasionally have to work... not leaders (in my experience)".

"In my maternity life: matrons = waste of space. Never seen doing anything clinical, rarely seen on ward. Never really cared about discussing care/staffing levels and never partook in doctors' rounds. Appeared to have no idea what was going on on the wards".

“I’d say our matron equivalents are managers who occasionally act as coordinators (not particularly well) but never work just as a midwife. Their focus, whatever they do clinically is always on management and policies, never the individuality of a woman or normality so no, I don’t see them as leaders”.

In summary, while the LMS interviewees conceptualised themselves as midwives, leaders and managers, forum respondents tended to have a far more negative perception, with matrons defined as managers according to the irregularity or absence of a hands-on role in clinical practice, or according to a perceived difference in focus. This is a strong contrast with the interviewees’ defence of their midwife identity, in which they are acting according to the central tenets of the profession, and in which midwifery can be conceptualised as going far beyond hands-on clinical work.

7.3.2 Earlier Career Views

Of interest here is an exploration of the interviewees’ own perceptions of clinical leaders at an earlier point in their careers. While they identified themselves now as midwives, with leadership and management incorporated into that identity, they did not necessarily see things this way when *they* were clinical practitioners, particularly at a junior level. For example, Lesley described how she viewed matrons and HoMs as managers when she was a junior midwife, compared with her current beliefs:

“All the people I respect are – certainly midwifery would be very true to their core. [BD: And when you were, you know, back in the day as an E grade, or an F grade, would you have seen it the same then...] No, not looking up... Maybe I just didn’t have enough engagement with leaders and managers”.

Similarly, Natalie reflected on her earlier views of the head of midwifery role:

“Certainly the head of midwifery was a true manager, and you didn’t see her. You were glad if you didn’t see her, because if you did go to see her, you’d done something wrong. And also, that’s how you saw supervisors of midwives”.

Natalie contrasted this with her view of the head of midwifery in another unit where she subsequently worked:

“When I then had my senior post, there even the head of midwifery would still come out and do hands-on if need be. And therefore I did see them as midwives”.

On the subject of matrons, Natalie remembered them as midwives rather than as managers, despite a lack of hands-on practice:

“In those days we called them nursing officers – they were always around, so – and they were in uniform. So although they might not have done hands on, you still knew they were – and felt they were – a midwife, because they were around and about, and they were in uniform”.

In contrast, Pauline thought of matrons as managers:

“When I think back to those years when I was a midwife, then, they had nursing officers, so the matrons weren’t around. So then, you would see them as a manager”.

Heather, meanwhile, saw matrons as midwives, in contrast with her perception of the HoM:

“I’d see my matrons probably as midwives, because they – I saw a lot of them. And the head of midwifery as definitely more of a manager”.

Louise was the only interviewee who, as a junior member of staff, saw heads of midwifery as midwives rather than as managers:

“I’m just thinking back, and I suppose it’s just the way I’d – I suppose I’d been brought up in midwifery, where I’d trained, I did see them as a midwife”.

Although Louise was unable to pinpoint the reason for this view, she described how she now perceived things differently, in part due to semantics:

“I think I’d change that now, if I look at it now, I think there’s – I see – you see them more as managers, because I – but I think that’s some of how you understand their role more, and where that sits. And I suppose because we’ve changed names, to clinical business units, and divisions, that you just see them as – as businesses and managers”.

Earlier perceptions of clinical leaders appeared to be based on questions of visibility (offices and uniforms) and clinical practice. Clearly, the Midwifery Sanctuary respondents held the same view, suggesting that perception is a result of exposure to and understanding of organisational structures. In the case of the LMS interviewees, there was also a determination to retain the self-identification as midwife, despite (or perhaps partly because of) their awareness of the perception held by clinicians.

7.3.3 Possible Futures

The LMS programme was designed as a way of preparing the next generation of heads of midwifery. However, it is perhaps surprising to summarise the future ambitions of the LMS interviewees, which are less clear than the programme organisers might have hoped for.

At the first interview, Deborah was keen to move on to a HoM role, particularly as a result of her recent secondment to the post:

“It’s given me that ability to now think, ‘Well, when I go into that role, maybe we ought – that might be an area to look at, that might be’... I mean, I’ve got some

ideas, you know, that I will put on the table for a head of midwifery post, because I know they are areas that, you know, where there are gaps”.

By the time of the second interview, several months later, Deborah’s feelings had changed. After some disappointment associated with being unsuccessful in HoM applications, and with the trust involved in a re-configuration, she had come to a different conclusion:

“And that’s it. I haven’t applied for anything, since (laughing)... I’m having time out, the way I see it, and mentally I need some time out. [BD: Yeah, it was quite an intense year, wasn’t it?] Well, four interviews in one year... So – but I just need time to re-focus and time to cope with, you know, the changes that are going off within the trust at the moment”.

Lesley, meanwhile, had applied successfully for a HoM post between the two interviews, and at the time of the second interview was about to take up her new role. As described earlier, Lesley was relishing the thought of new challenges and greater control of the service:

“I could be completely wrong, but I feel I’m ready for it. I did think I’d have maybe three, four years in this job, because I looked at it as sort of my apprenticeship”.

For Natalie, there was a sense of uncertainty in relation to her possible future career moves at the first interview:

“I’m happy where I am, but as I’ve now got to work until I’m 66 – because I missed the 60 year old by 10 days (laughing) – that gives me another 15 years of work, and life doesn’t stand still. Who knows what opportunities there will be? Whether I would end up looking more strategic level and going into championing midwifery in different ways, I don’t know, because – The difficulty looking at head of midwifery,

I'd be conscious I am not clinically credible... That said, I am hoping to be successful in applying to become a supervisor of midwives".

By the time of second interview, Natalie remained LME, but had begun training to become a supervisor of midwives, as well as beginning a professional doctorate. She felt the LMS programme had given her a new impetus:

"I feel for credibility, it's key. But also, it's something I wanted to do for years and years. At least ten years... It's a way of still being involved to a certain extent with practice, without doing everyday practice".

At the first interview, Pauline was new in a matron post, and was unsure about whether she would go on to a HoM role:

"I have not got a clear direction of where I choose to go. Head of midwifery is not something that I – I wouldn't say definitely no to. It is something that – I could rise to the challenge (laughing). Maybe when I get – when I achieve what I want to achieve here, and they, you know, you feel... But at the moment, I have a lot of stimulation here... to keep me here, and I'm, as I said, I'm just enjoying it, because it is a big remit, and if you've got a brilliant team, then – you know, it all goes hand in hand, really, and I'm just quite happy where I am".

At the second interview, Pauline remained content as a matron, although she did not completely rule out a HoM role somewhere in the future:

"It's the best choice, best move – opportunities, and development and, you know, job satisfaction, and work life balance, and everything. It just ticks all the boxes, really, and this is why I think I feel – I don't know if – if I feel I need – if I want to progress further up the ladder. I'm actually quite happy where I am. But then, I

know there comes a time where you might feel that you've stagnated and you want to stimulate the brain... I feel I'm at the right level for me, for now".

For Louise, circumstances dictated her career decisions. At the first interview, she too was new in the matron role, but in her case it was a secondment, and she was deciding whether to apply for the substantive post:

"I've kind of concluded that I'd be mad not to. It's a fantastic opportunity. I have been doing it. In some ways, I've felt that I've grown to be capable of doing it. But I think fate will have that – idea, in terms of interview, and how I get on with that, compared to others that I know will go for it".

Fate turned out not to be on Louise's side at interview, and she was unsuccessful in her application. However, she was offered a further secondment to a different matron position, which she had begun at the time of the second interview. Because the role was again a secondment, and was based on a colleague's maternity leave, Louise felt some uncertainty about what she would do in the future:

"Yeah, it might be a very different situation in a year's time, and you [the colleague on maternity leave] kind of learn to adjust to sort of two children and all of that, so I'm still kind of left, 'What do I do?' I've got a lot of – now – experience behind me, and I have to kind of look to considering whether I look elsewhere for a more sort of substantive post that gives me that sort of definite".

Rather than a HoM role, however, Louise was considering a matron-level post. On the subject of whether she would apply for a HoM post if it became available:

"That's still too far away (laughing)".

Heather seemed the most unsure of her future in the first interview, reflecting on her matron role. While she did not experience a conflict of her midwifery identity per se, she admitted to feeling uncomfortable with the management (rather than leadership) side of life as a matron:

"I struggle with it sometimes. I have far more loyalty towards my clinical side, and I think I always will have, and that sometimes makes me doubt whether I'm actually in the right role. And I've been questioning myself a lot, recently, about really whether I'm where I should be. Because although I find the strategic stuff quite easy, actually, I don't find it a problem, I can do it... It's not really where my heart is. So... I'm not quite sure where my path will go".

During that interview, Heather described being drawn to the consultant midwife role, but by the second interview she had changed her feelings, and was now considering something quite different:

"But I'm actually wondering what my next – thinking about my next role, and where I progress to after this. Whether that may be – it's not here, and whether it's... overseas".

And having struggled with where her loyalties lay, Heather had now decided that a midwifery management career was right for her.

Caroline, as described earlier, reflected on whether she might be thinking about moving to a new role, had the LMS programme come at an earlier stage in her career. As it was, she was planning for retirement:

"The stage I'm at, I've only got 15 months left in my career, before I retire, so for me, I feel I've – I've had several careers over my life, and I've done – done a lot... [BD: Are you ever tempted to stay on?] No, because I planned on retiring at 55, because

that's the next stage of my life, and I might want to train and do something else, or I might want to do nothing. I might want to open up a coffee shop".

In a similar vein to Caroline's narrative, Karen was also considering when she might like to retire, and this was having an impact on consideration of future career moves:

"I probably will finish in five years' time, but I think part of that is my safety net, thinking that, 'Well, if it is that bad, I could finish in five years' time. And if it's not that bad, I'll keep going'. As I said, I'd be very much in two minds about sort of applying for a head of midwifery post here, in the current climate, in the current set up. I think to apply for a head of midwifery post elsewhere, it – it would have to be, you know, sort of a unit that was close by, with some sort of pay progression that made me feel that, you know – it makes you feel worth it, and that it would be that challenge aspect of you know, 'Yeah, I'm at a stage where that would be another challenge'. On the same vein, if I think I've got to travel 50 minutes to work and back, on top of the long – what would potentially be a long day – then, you know, I'd think I'm quite happy to stay another five years or whatever here, providing the challenges keep coming, really".

Finally, Susan, as LSA MO, was being challenged by structural changes within the SHA at the time of her interview. Considering whether she would take on a HoM role again, Susan was clear in her thinking:

"No...I don't go back. I don't think that's a good move to make. I think the heads of midwifery nowadays have a very hard job".

The current situation within the SHA was creating some uncertainty about her role, and making it difficult to think about the future:

"I think, if we weren't going through transition, I don't know, it might be time for me to move on. But because we're going through transition, there's no way I'd go at the moment. Because if I leave, I don't know if they'd replace me. And actually, if my – the ethos of my being is that I'm here to do the job, I can't leave knowing... that there's – we don't know what the replacement would be. We don't know".

Again, the subject of retirement was raised:

"I look at it and I think, 'What next?' I mean, yeah, I could retire, but I'm not ready to retire (laughing). If I retired, then I'd go and do something else anyway. Whether it would be in midwifery or whether it would be in nursing, no idea! Life's too short, you know, sort of – you just seize whatever opportunities – there's too many diverse things out there".

7.3.4 The HoM Challenge

Perhaps the most interesting element in discussions of possible futures among the interviewees related to the idea of moving on to a HoM role. While several of them had had exposure to the role, either through acting up or through a secondment opportunity, or in Susan's case having done the job before, they remained largely unsure about taking on a HoM post permanently. Lesley was the only interviewee to embrace the role, with all the others far more hesitant.

When I discussed this with the interviewees, several key themes emerged. The first related to their thoughts about the HoM role generally, where was a consensus of opinion that HoMs were over-stretched. Deborah spoke of the lack of purity to the role:

"I would [consider a HoM post], if it was a proper head of midwifery role, without all the other issues thrown in, like, you know, when – you know, the variations on a theme are usually HoM/QUILL, or HoM/general manager, or HoM/general

manager/lead nurse... So if – you know, if it was purely professional head of midwifery. But they seem to be few and far between”.

Similarly, Heather found the large remit of the HoM role unattractive:

“You know, it’s almost like a head of midwifery doesn’t exist any longer, it’s now head of women’s services, or head of midwifery and gynaecology, head of women’s and children’s. It’s – you very rarely see a head of midwifery... I don’t really want to be head of gynaecology. I don’t want to be head of paediatrics. I mean, what do I know about those specialisms? You know, and even if you’re a nurse – you’re an adult nurse, that you trained – and your registration’s lapsed 10 years ago, what would you know about those anyway? I just think it’s – you know, they’re trying to make – put midwifery in, and almost dilute it by adding other factions because, you know, they haven’t got the money to provide their own”.

As suggested by Heather, the role would be attractive if it were simply a head of midwifery post, an argument echoed by Karen when I asked her whether she thought the HoM role was a poisoned chalice:

“I think the head of midwifery job, post, role, by itself is not. And I think it’s the additional pressures that come from outside... the pressure that they put you under around running that aspect of a huge service, but then also have to contribute to the on-call service for the whole hospital, have to contribute to bed management for the hospital... You know, if you’re left to do the head of midwifery role, and concentrate on developing that service, using the resources that you’ve got to their best potential, I don’t think it is a poisoned chalice, and I think it’s a – a fantastic opportunity. I think it’s tainted by everything else that’s added to it... I think it’s people don’t appreciate what maternity services are”.

The size of the HoM remit had an impact on consideration of interviewees' work-life balance if they were to take on the role:

"The commitment that they have to have to do that role, and the size of the role, I would not want to do it. Because for me, it would impact not only – it would impact on my whole life. It would impact on the amount of time that I would want to spend with my family at home, my husband, doing what I want. Because I see the hours that that role takes up, and I see a head of midwifery... On a near enough every day basis, to be here from 7 in the morning to 7, 8 at night is not what I want in life, it's not. And it – it doesn't attract people to that role, and that's the problem – it doesn't attract people" – Caroline, PDM.

As well as problems with work-life balance, there was also mention of the challenge of maintaining a true midwifery identity at this level:

"The head of midwifery post has really been brought up into the sort of nursing exec team, and – and you know, it's difficult at times, when you're trying to be the professional lead, keep in touch and contact with what's actually happening on the shop floor, but also being – having to be aware of all the trust issues and what's on the board's agenda, and what's on the, you know, the chief nursing officer's agenda and the director of nursing and what have you" - Deborah, matron.

The combination of these factors – the large remit, the impact on work-life balance, and the challenge of maintaining a commitment to the midwife identity – was what made the HoM role unattractive, rather than a feeling of not being capable of doing the job:

"I just think to myself, for an extra banding, do you want all that grief and all that hassle? You know, I take my hat off to them, because they're doing a fantastic job. And there's no reason why I can't do that job, I'm not saying I can't do it, but then

would I get the same satisfaction that I'm getting now, because of the roles – the responsibility that you have? And the expectations from you – because you are managing the unit, maternity services, you are the head. And it is a big responsibility, and I – I – at this current moment in time, it's not appealing to me at all, no" – Pauline, matron.

Possible Future

After four years away from clinical practice, would I want – or be able – to return to the frontline?

There are times when I miss it – I loved being part of a team, I loved feeling like I made a difference to people's lives, I loved being part of the childbearing experience. But like I said before, the idea of being a band 6 midwife with a PhD is somewhat nonsensical – not enough opportunity to make a difference at that level, in my experience. Although my daughter did suggest it would be highly amusing to be wearing the band 6 uniform with a badge saying 'Dr'.

Having spent so long immersed in the subject of midwifery leadership, I find myself less and less attracted to it as a career option. I think a large part of this is down to my reflective nature: I don't think I'm a 'natural' leader in a managerial sense. I probably would be quite good at coming up with ideas, and I generally function well in a team environment, but I know (now, more than ever) what clinicians think about those who are confined to offices. And I wouldn't want to have to fight that perception on a daily basis.

So I expect I shall stay within research. I like it here, too. I like to find things out and

consider where problems might stem from, and try to solve puzzles around working lives and the tensions within the profession. Like I always say – I’m quite nosy, really.

But where to live? Having spent four years in the business school, I’m not convinced that’s the right environment for me. Not that I don’t love theory these days, but in midwifery research there would be a million practice and policy based things for me to be nosy about, all of which would interest me greatly. Like my supervisor once said, perhaps I should consider this four years as a holiday to a strange planet – and I can bring lots of souvenirs back to my home planet; one of which would be a theoretical way of approaching problems, which would only be a good thing.

7.4 Conclusions

In this final data chapter, I have explored the clinicians’ side of the clinical leadership narrative in midwifery. A striking counter-narrative was presented, which offered a stark contrast to the motivations and beliefs expressed by the LMS interviewees in relation to clinical leader identity construction and enactment.

Finally, possible futures of the online respondents and the LMS interviewees were explored, and there was evidence of a link between the narratives and counter-narratives which had at first seemed poles apart. It seems that all study participants were aware of the possibility of the erosion of the midwife identity. Understanding where in the organisational hierarchy this erosion began was clearly linked to a combination of perception, socialisation, and exposure to roles.

In the next chapter, I will discuss the study's findings. The data presented in these three chapters will be examined in the context of the theoretical framework, principles of contemporary leadership theory, and the advent of clinical leadership as an NHS ideal. Finally, I will introduce ideas of liminality to explore the development and enactment of a hybrid clinical-managerial identity, drawing together the strands of individual, professional group and organisational analysis presented throughout this work.

Chapter Eight: Discussion of Findings

8.1 Introduction

The purpose of this chapter is to discuss the study's findings in relation to the research questions and the view of contextual and theoretical literatures. Through a process of scrutinising significant themes, the study's contribution to theoretical and contextual knowledge can be identified, and conclusions and recommendations can be made.

The objective of the study was to explore issues of identity construction in NHS clinical leadership, using the case of midwives as an exemplar. I adopted an interpretivist approach to explore the research questions, as this is strongly associated with answering questions of 'how' and 'why' (Wilson, 1998:4; Willig, 2001:9). Specifically, I used case study and narrative methodologies, with periods of observation, in-depth narrative interviews and online interaction as the chosen methods of data generation. I also took a strongly reflective and reflexive approach throughout the study, based on my self-awareness as researcher and formerly clinical midwife.

While data analysis was strongly focused on a narrative approach, I also employed coding and categorising of emergent themes, in order to gain mastery over the sheer volume of data arising from the various elements of the study (Seers, 2012).

Having presented the results of the data analysis in the previous three chapters, I now turn to a discussion of the findings at theoretical and contextual level, and then move on to examine results in relation to the study's guiding research questions, which were:

1. How do exogenous and endogenous factors influence the transition to and enactment of leadership among midwives?

2. What are the development needs of midwives to promote new ways of working and drive system wide change in the NHS and how might these be achieved?

In order to fully discuss the study findings in a clearly-structured manner, the chapter will proceed as follows:

- I first focus the discussion in relation to the question, ‘What do the findings say in relation to clinical leadership and its development?’ I examine the significant emergent themes, which can be identified at individual, professional group and organisational levels, and place them in the context of wider leadership literature;
- Second, I show how findings support ideas of interplay between role and social identity, examining this interplay in relation to theoretical thinking around identity construction. I discuss findings in relation to the place of narratives in role identity transition, in view of the strong interplay between individuals and their relevant professional and organisational context. Discussion is related to the over-arching theme of the study findings, conceptualised as ‘I am still a midwife’;
- I then return to the research questions and introduce ideas of liminality as an explanatory model for identity construction and enactment in clinical leadership.

8.2 Problems in Clinical Leadership among Midwives

The study findings showed the nine central interviewees as passionate individuals, fully committed to their professional identity as ‘midwife’, and employing a strategy of role incorporation in order to avoid identity conflict at the individual level. This was seen in their self-description of ‘I am still a midwife’, despite generally holding no regular clinical role. They described midwifery as far more than the hands-on ideal suggested by the online respondents, and the interviewees’ conceptualisation was in fact closely related to NMC (2010) and ICM (2011) definitions of the role.

There will be further discussion of the midwife identity later in the chapter, when I relate the central theme of 'I am still a midwife' to the study's theoretical framework. For now, however, the focus of the discussion will be centred on what the study findings have to say about the challenges in NHS clinical leadership. Several key themes emerged in this area, and the following sections deal with each of these in turn, with findings examined in the context of relevant literatures.

8.2.1 A Surfeit of Leaders 'Ready Now'?

This theme relates to the issue of career progression after leadership programme completion. At the first interviews, which took place only a few months after the LMS programme, participants were generally enthusiastic about potential futures, in most cases giving consideration to where their careers might take them next. Several interviewees were engaged in applying for HoM posts, while others were considering moving on within the next couple of years. In essence, there was a generally positive atmosphere around questions relating to further career progression.

However, at the second round of interviews, a significantly different picture emerged. For example, Deborah had been unsuccessful in several HoM interviews and was re-considering her future in the light of her trust undergoing a service re-configuration; Louise had been unsuccessful in applying for a substantive matron post, and remained in a state of limbo in a continued secondment role; Pauline had decided that the HoM role appeared unattractive, having now been exposed to it as a matron who on occasion was required to 'act up' for the HoM, for several months.

Of significance is the fact that thirty LMS delegates were developed to a point where they were considered ready for career progression, ideally to HoM and beyond. However, very few roles became available, which inevitably meant disappointment for some of the

programme participants. While being 'ready now' is an organisational strategic vision, it is interesting to consider what happens to those individuals who are then left waiting for opportunities to arise.

The organisational structure is relevant here: the LMS programme provided a short-term learning and development opportunity, but data show that individuals risked losing momentum and motivation gained through the development process, if they returned to the post they already held and did not have a sense of continued development. This was evident in the interviewees' perceptions of both SHA support and coaching experiences: interviewees expressed surprise and some disappointment that the SHA did not provide sufficient structured follow-up opportunities after the programme ended; and those who had gained exposure to coaching were keen for this to continue.

The LMS programme was developed in the context of a recent NHS move to embrace the concept of talent management (NHS Employers, 2009). Talent management is a concept imported from the private sector, where it has been described as a way of moving succession planning towards action-oriented activity rather than static processes (Clake & Winkler, 2006:1). A key element of a talent management approach to development is the interaction between career development of the individual member of staff, and succession planning in relation to the organisation as a whole (Yarnall, 2009). The CIPD (2007:3) offers a concise definition of the term:

"The systematic attraction, identification, development, engagement/retention and deployment of those individuals with high potential who are of particular value to an organisation".

There has been significant debate in private sector commentary on issues such as which members of staff should be managed as 'talent', with authors generally agreeing that a

whole organisation approach is optimal (Stockley, 2005; Cook & Macaulay, 2009; Higgins, 2008). A further part of the debate has been around which part of the organisation should take responsibility for talent management, with suggestions that line managers (CIPD, 2007:4), senior managers (Cook & Macaulay, 2009) and human resources departments (Chambers *et al*, 1998) should all be accountable for developing talented individuals throughout the organisation. Central to the success of a talent management approach to individual careers and organisational succession planning is the development of a 'talent culture' (Blass, 2007:10), which can only be possible when all members of the organisation understand the importance of investing in a talent management strategy (Cook & Macaulay, 2009).

From an NHS perspective, the Next Stage Review (2008) was the key driver in embracing a talent management approach. The stresses on the future needs of the organisation have been clearly stated in relation to NHS leadership more generally, and include demographic pressures such as an ageing workforce, and an increasing recognition of the importance of a diverse workforce (NHS Employers, 2009), embodied in the advent of distributed leadership ideals within the organisation. The value of embedding talent management within the NHS has been described in terms of its importance to staff retention at all levels, and for succession planning (NHS Employers, 2009).

However, while a Department of Health document, 'Inspiring Leaders: leadership for quality' (DH, 2009a), describes a new commitment to talent management, there is equally recognition that the organisation has historically failed to systematically identify, nurture and promote talent and leadership (p4), and an understanding that behaviours will need to change if a culture that fosters leadership development is to be developed (p27).

In the leadership narratives of the LMS interviewees, there was clear evidence of the lack of a structured approach to career development for clinicians in the NHS, a finding which

echoed the wider clinical leadership literature reviewed for this study, particularly in comparison with the clearer career trajectories of general managers (Ham *et al*, 2010; BMA, 2012). As discussed in various papers on the subject (BMA, 2012; Osborne, 2011; Phillips & Byrne, 2013), the interviewees had had little or no structured leadership development prior to employment in a line manager position, and opportunities for their individual development had been ad hoc and generally reliant on their own self-motivation. However, the role of mentors was notable in the study, as such individuals were able to offer guidance and encouragement to the interviewees in relation to trying new opportunities and applying for new posts; but again, this had happened on a generally informal basis, rather than as part of a structured approach to career development.

A significant element within a talent management approach is the continued development of individuals, with a career-long perspective suggested as the ideal if a 'talent pipeline' is to be embedded within the organisation (Gandz, 2006; Cook & Macaulay, 2009). However, as I will discuss in the next section, having been identified as talented within the workplace, and having been offered the opportunity for tailored career development via the LMS programme, the organisation did not appear to continue to offer any real support in relation to enacting learning in the workplace or ensuring continued career development opportunities were available for the programme participants.

8.2.2 Disappointment and Disillusionment

Interviewees described numerous positive aspects to the LMS programme, particularly in relation to networking and coaching opportunities. The 'space' gained through development opportunities away from clinical life – whether physical or emotional – was considered extremely valuable. However, the return to 'real life' was associated with some degree of disappointment.

There was the challenge of enacting a transformational model of leadership, which was the classroom ideal encouraged during the programme, within an organisation where a transactional approach is largely the norm. While the interviewees described themselves very much in terms of transformational leadership characteristics, in their day to day work life they spoke of the tasks associated with command-and-control, hierarchical, transactional models of leadership, such as line management responsibilities, governance issues, and trust-level imperatives.

As I suggested in the literature review concerning transformational and transactional leadership within the NHS and beyond, there is a general acceptance of the requirement for both models of leadership within an organisation, with different approaches necessary depending on context and circumstances (Boseman, 2008; Bass, 1990; Deckard, 2010:212). In the LMS programme, the focus was very much on leadership for change, with seminars and action learning sets addressing broad and specific problems associated with change leadership in the contexts within which delegates were working. In these circumstances, a transformational model of leadership would be considered applicable, due to the need to engage followers in a leadership vision and demonstrate understanding of followers' concerns and requirements in embedding a change within the organisation (Bass, 1990; Bass & Avolio, 1994; Bolden *et al*, 2003:16). The interviewees described examples of change leadership they were keen to bring back to the workplace on completion of the LMS programme, and had a desire to utilise the behaviours and characteristics they had developed.

However, the reality of the workplace appeared much more aligned with suggestions from the literature, in which leadership in the NHS is situated within a transactional, hierarchical, command-and-control model (Millward & Bryan, 2005; NHS Confederation, 2007:3; Firth-Cozens & Mowbray, 2001). The problem for the interviewees related to a disconnect

between classroom learning and NHS activity. Despite criticisms of the traditional NHS leadership model, and significant attempts to engage with transformational leadership demonstrated in the LMS course structure, the reality for interviewees was that the organisational context had not yet embedded a combined model of leadership within its structures (Alimo-Metcalfe & Alban-Metcalfe, 2000).

Significantly, interviewees found themselves unable to exploit newly-formed peer group networks which had been successfully implemented and encouraged at the LMS programme. While interviewees believed they might be able to pick up these networks in the future, should the need arise, there was a sense that time pressures precluded them from doing so in their normal working lives.

This problem of bringing learning effectively back to practice, and the organisation being unable to support new ways of working – such as the maintenance of peer group networks – echoes the findings from other studies of clinical leadership in healthcare. Time pressures associated with daily life in the NHS (Storey & Holti, 2013), and a de-contextualised learning environment (Howieson & Thiagarajah, 2011) were both significant factors in the sense of disappointment expressed by interviewees, and can be seen as related to the wider problem of NHS reliance on transactional models of leadership (Firth-Cozens & Mowbray, 2001; NHS Confederation, 2007:3).

8.2.3 Lack of Validation by the Professional Group

As described in the previous section, LMS participants returned from the programme believing strongly in their ability to engage with their clinical colleagues according to a transformational model of leadership. However, as they described their day-to-day activities, there was a clear picture of normal activity as transactional leadership, or as the online respondents called it, management.

The results of this disconnect were strongly evident, demonstrated when interviewees described the challenges of enacting leadership while holding what their clinical colleagues would call managerial roles. While expressing disappointment in this prejudiced view, interviewees were able to empathise with clinicians to a degree, understanding from their own earlier career preconceptions why clinicians might think of them as managers.

The leadership and management debate has been in progress for a good number of years. The main problem appears to lie in leadership as an elusive concept (Bennis, 1959), holding different meanings for different people (Yukl, 1994:2). The result of this elusiveness has been a plethora of definitions and disagreements (Stogdill, 1974:259).

Many attempts have been made to distinguish between leadership and management (NHS Confederation, 1999). For example, Kotter (1990:4-5) describes clear differences between the two concepts:

- Leadership is establishing direction, aligning people, motivating and inspiring;
- Management is planning and budgeting, organising and staffing, controlling and problem-solving.

Elsewhere, there have been suggestions that a high degree of 'conceptual fuzziness' exists in deciphering meanings of leadership and management. Edmonstone & Western (2002), describing the evaluation of NHS leadership development courses, found that challenges lay in establishing the differences between leadership and management, identifying distinctions between managerial and clinical leadership and relationships between them, and defining the contrast between command-and-control and distributed models of leadership.

Similarly, much intellectual energy has gone into establishing definitions and conceptualisations of 'leaders' in contrast to 'managers'. Zaleznik (2004) describes in detail

what divides the two groups, while Drucker (1955) popularised the idea that the key definition of leaders is that they create vision (Rees & Porter, 2008).

However, stark distinctions are not necessarily seen as helpful. Degrees of overlap between leadership and management, or leaders and managers, are the contested issue, rather than assuming that the two concepts are dichotomous (Yukl, 1994:4; Rees & Porter, 2008). Mintzberg (1989), for example, in a study of chief executives in the USA, found that the leadership role was a sub-set of a broad range of management roles, while Kotter (1990:9) suggests that there is a danger inherent in suggesting leadership is intrinsically 'good' while management is 'bad'.

Within the NHS, this idea of 'good' leadership and 'bad' management has been examined in recent years (Ham, 2012; Kings Fund, 2011). The Kings Fund report into NHS management (2011) suggested there has been a historical association between management and ideas of control, which was the result of the Griffiths report – an idea also voiced in clinical leadership literature discussing the conflict between clinicians and non-clinical leaders and managers (Dopson & Fitzgerald, 2006; Ham *et al*, 2010; Nicol, 2012). Ham (2012) suggests there has been a failure at government level to value managers alongside clinicians, but believes there is an essential role for managers in a well-run health service, as they offer support to clinicians, for example in managing budgets. The Kings Fund report (2011) concluded that it was important to share management and leadership between managers and clinicians, and contrasted this view with examples of the denigration of managers at government level, exemplified by Alan Milburn's attacks on 'men in grey suits'. Meanwhile, the report mentioned the negative public perception of NHS managers, citing an Ipsos MORI poll from 2009, in which 85% of those asked supported proposals to reduce the number of managers in the NHS by one third.

In this context, it is perhaps unsurprising that leadership and management were contested issues in this study. The online respondents clearly defined midwifery leaders without a clinical role as managers, and the term 'manager' had highly negative connotations. This was a source of frustration on both sides of the clinician-service leader divide: the LMS interviewees described challenging the managerial stereotype presented to them in practice, and were able to articulate elements of both leadership and management within their role identity as clinical leader; the online respondents made judgements and assumptions about the career motivation of clinical leaders, constantly referring to them as 'the management' and describing the disempowering effect they had on clinical midwives attempting to practise in a hierarchical structure.

What was notable in relation to group-level assumptions about clinical leaders as managers, was the response described by the interviewees when they actively challenged the views expressed by clinicians – that the root of all their ills was poor treatment by 'the management'. As I described in chapter six, when confronted with the idea that they were in fact talking to 'the management' in the form of the matron or head of midwifery, clinicians immediately rejected this idea, instead suggesting that 'the management' resided elsewhere in the organisation.

The findings from this study, in relation to the challenges to clinical leadership based on poor articulation of leadership and management, are supported by the wider literature, both within (Ham, 2012; Nicol, 2012) and beyond the NHS (Yukl, 1994; Bennis, 1959). Being perceived as 'management' rather than as 'midwifery leader' appeared to have considerable impact on the interviewees, which was reflected in three areas. First, they reflected at length on issues of visibility. This was closely linked to the question of credibility, but there appeared to be no ideal solution to the conundrum of remaining visible and accessible to clinicians, as well as being visible and accessible to other members

of the leadership and management team. Interviewees described benefits and challenges associated with having an office situated in either the clinical area or the management corridor, with insight from Heather and Louise of particular value given their moves between the two areas.

The second area where the perception of being part of 'the management' impacted on the interviewees was within communication. Interviewees described their intra-group communication in terms of speaking 'as a midwife'. Their shared history with clinicians was the root of an ability to speak the same language, and interviewees described how this shared language and history meant they were able to bridge a clinical-managerial divide. From the perspective of the online respondents, there was a rejection of service leaders' assertion of a shared language. Rather, they spoke of managers having forgotten what it was to be a 'real' midwife, and described communication as poor, dismissive, or indeed non-existent. The question of shared language and history will be returned to later, in the discussion of findings related to theories of identity.

The third significant area of perception related to clinical activity. Although the interviewees had largely had to relinquish any substantial clinical role, due to the demands of a leadership role, there were many descriptions of trying to work clinically on an ad hoc basis, for example when the unit was excessively busy or short-staffed. The problem they encountered might be described as an encroachment of the managerial element of their role into the clinical area: while trying to care for women, they were called away to phone calls, or clinicians attempted to make management-related requests. This challenge was echoed in the online respondents' comments about service leaders working in the clinical area, with disparaging comments about them being, for example, 'expensive cleaners' when clinical leaders assisted in clearing rooms. Again, a conundrum was evident: interviewees wished to spend some regular time in clinical practice, and online

respondents demanded this as the most significant element of a continued midwifery group identity. However, the nebulous nature of 'clinical practice' meant little idea was gained about how much time in practice would be considered ideal from either group's perspective. Meanwhile, as Susan pointed out, there was a worry that if clinical leaders were engaged in practice, who would be providing strategic leadership on behalf of the profession?

The key issue was one of credibility: while the interviewees were able to describe numerous ways in which they maintained a credible midwifery identity, the view from online respondents was quite different. Here, there was a perception that if service leaders did not work clinically, then the midwifery group identity was not applicable. Further evidence was seen in observations recorded at the band 6/7 leadership programme, where possible futures revolved around roles considered 'pure' midwifery, all of which involved some element of clinical practice.

The attractiveness of leadership and management roles (or lack of it) in relation to credibility was where there was evidence of some symmetry between interviewees' and online respondents' views. Both groups expressed a strong desire to maintain a credible midwifery identity throughout their careers, with the only real difference being at what point they would consider credibility to be lost. Online respondents suggested that any role described as 'management' threatened membership of the professional group due to a lack of clinical credibility. Interviewees, with their broader horizons, spoke in terms of retaining a core *self*-identity as midwife no matter how high in the organisational hierarchy they might rise, but did express concern that their professional *group* credibility might be threatened if they were to take on an expanded HoM role.

The study findings are closely aligned with previous research into clinical leadership challenges in relation to credibility. This has been identified at individual and group levels,

as was the case in this work. At the individual level, LMS interviewees expressed a sense of loss at relinquishing their clinical role, which was similar to the findings in Ham *et al's* (2010) study of doctors in clinical leadership. At the group level, Osborne (2011) found that clinicians held highly negative views of clinical leaders without a caseload, which was exactly what the online respondents expressed in this study.

8.2.4 Lack of Validation by the Organisation

In the previous section I described challenges of clinical leadership in relation to professional group acceptance and validation. The discussion now turns to a similar challenge, this time in relation to organisational attitudes and understanding.

As I described in chapter six, a key observation related to the description of the LMS delegates – which came from a former NHS trust chief executive – as ‘the cream of nursing’. This remark elicited much discussion at the study day among participants, and I referred to it in subsequent interviews. A significant theme emerged from the interviewees’ responses: the idea that they were a branch of nursing. While interviewees did not show any disrespect to their fellow professionals, they were keen to describe the differences between themselves and nurses. The sense from the interviewees was that while the groups could work effectively alongside each other, and indeed had much to learn from each other, midwifery should be seen as a separate profession with its own identity, based on the guiding principles of professional autonomy and birth as a normal physiological process, which was contrasted with the philosophy of nursing, related to the maintenance, improvement or recovery of health (RCN, 2003). Interviewees felt the ‘cream of nursing’ remark reflected a widely-held belief within trust management, that midwifery was part of, or the same as, nursing, and they expressed frustration at this idea.

There was a strong indication within interviews that the lack of understanding in relation to the midwifery identity was reflected in the expansion and ‘muddying’ of the HoM role. Interviewees believed there should be purity to the role, and that additions to the HoM role, such as gynaecology or paediatrics, were unhelpful, and decreased their attraction to the role. As an example, Heather expressed the idea that she would not be keen to move to a HoM role unless there were no additional responsibilities, and related her direct entry status to this assertion. From a different angle, Deborah felt disappointment in the possibility that, following a service reconfiguration within her trust, there might be a nursing matron overseeing maternity services.

The views of interviewees on the organisational conceptualisation of midwifery were significant in the light of concerns about the future of leadership within the profession. As described in the literature review, reports into maternity service failings have consistently highlighted the challenge of communication and leadership within and beyond the profession (HCC, 2004, 2006; Fielding, Richens & Calder, 2010). Similar concerns were echoed within this study, with two points particularly significant: first, at the organisational and strategic level, there has been considerable attention directed towards the question of midwifery leadership. Policy documents have described the importance of strong and effective leadership within the profession (DH, 2007; DH, 2010), the potential problems associated with an ageing workforce (DH, 2010; HCC, 2008), and the significance of a midwifery voice at trust board level (DH, 2007). However, this study has suggested that government-level rhetoric is not matched in the experiences of midwifery service leaders, who have been left with the impression that the profession is neither well-understood nor adequately acknowledged at board level.

Second, there is a direct impact on the future of midwifery leadership, if the beliefs of both the LMS interviewees and the online respondents are reflective of the wider midwifery

population. As described above, the HoM role was considered unattractive by the majority of the interviewees (Lesley being the notable exception), due to the perception of an over-sized remit and consequent impact on issues such as work-life balance. It is notable that interviewees developed their opinions of the HoM role on the basis of direct observation, and in some cases experience, in contrast with the negative views of the online respondents which were largely based on stereotyping and prejudice.

8.2.5 Conclusions

This section of the discussion has addressed the study findings in relation to the challenges of clinical leadership development and enactment in the midwifery profession, contextualised within broader leadership literature and current NHS thinking. Specifically, study themes identified challenges in a number of areas:

- Timing and methods of leadership development programmes;
- Organisational commitment to continued development beyond LMS;
- Validation of a clinical leader identity at professional group and organisational levels;
- Impact of clinical leadership challenges on midwifery leadership in the future.

8.3 'I am Still a Midwife'

In the next part of the discussion, I turn to the over-arching theme of the study findings, which can be conceptualised as 'I am still a midwife'. At the individual level, interviewees were confident in asserting this self-identification in whatever role they currently held, or indeed felt they might hold in the future. However, as the previous section has highlighted, the midwife identity in leadership and management roles is contested at professional group level, and appears poorly defined or understood at organisational level. Thus, the interaction between individual, professional group and organisational structure in clinical

leadership identity construction and enactment becomes clear. As described in the theoretical framework presented in chapter two, the study employed ideas from role and social identity theories to explore identity construction, and in the next section of this discussion I address the theme, 'I am still a midwife' in the context of the interplay between role and social identity.

8.3.1 Commitment and Salience

At the root of the interviewees' assertion, 'I am still a midwife', lay a continued commitment to the professional identification as individual and group member. Interviewees were able to give many reasons to justify this identification, related to the idea that 'midwife' remained the most salient role and social identity, and they incorporated management and leadership roles into an expanded midwife identity. Significantly, while the interviewees described a clear transition from a purely clinical role to one involving leadership and management, their commitment to the midwife identity remained constant.

Role identity theory would suggest the possibility of a conflict in identity in the case of clinical leaders, given the demonstrable challenges of developing and enacting a professional-managerial role identity (Thoits, 1992). On the other hand, some authors believe that because identities provide individuals with purpose and behavioural guidance, self-esteem is increased by holding more identities and being strongly committed to them all (Desrochers et al, 2002; Stets & Burke, 2003). In the clinical leadership literature, problems of role identity have been described in terms of dichotomies: *either* a professional *or* an organisational identification, with role conflict associated with attempts to manage the hybrid role interface (Edmonstone, 2008). However, the interviewees' descriptions of managing this interface were more closely aligned with suggestions that it is possible to operate in a more fluid, less fixed model of hybrid professional-organisational

identification (Iedema *et al*, 2004; Kippist & Fitzgerald, 2009; Ham *et al*, 2010), and this role incorporation appeared to be the mechanism through which identity conflict was avoided.

8.3.2 Group Identification

Individuation is described in social identity theory as part of the compromise involved in dealing with tensions between individuals' need for uniqueness and distinction, and the need for validation and similarity to others (Brewer, 1991). Interviewees used individuation in relation to descriptions of what they were not: neither nurses, nor doctors, nor general managers. Other professional groups were used as comparisons in relation to the interviewees' self-identification as midwives. This comparison was not necessarily made in a derogatory sense – nurses were considered a group in their own right, but different in essence from midwives. General managers were the commonest reference group, the significant element being their inability to work clinically should the need arise. Again, while the general managerial group was used as a comparison point to accentuate what midwifery leaders considered themselves not to be, there was a sense that while general managers might be considered inferior in a clinical sense, they had a role to play alongside midwifery leaders. This understanding of the value of other groups in the enactment of leadership and management supports other clinical leadership studies (Ham *et al*, 2010; Hoff, 1999), in which a strong professional identification led to little sense of division from general managers, as they were perceived as valuable in their own right.

Non-clinical managers also provided a reference group in the process of de-individuation, through which interviewees justified their continued in-group membership (Brewer, 1991). The other group used in this process was of course the midwifery professional group, to which interviewees showed a strong commitment. As described earlier, this process of 'othering' an out-group (general managers cannot work clinically) and in-group emphasis

(we are midwives because we can still take on a clinical role) was highly significant to the interviewees' continued self-identification at both individual and group level.

Comparison and categorisation are central to both role and social identity approaches to identity construction (Burke & Reitzes, 1981; Stets & Burke, 2003; Tajfel & Turner, 1979). One identity is always constructed in relation to another identity, whether this is at individual or group level. The interviewees' comparisons demonstrated this aspect of identity construction very clearly, with comparisons to both in-group and out-group emphasising their continued identity at the group level, and interaction with clinicians based on what they believed to be an undisputed shared history and language at the individual level.

So far, identity construction at the theoretical level has appeared largely unproblematic: midwifery leaders remained committed to their professional identity, dealing with potential conflicts of identity by incorporating leadership and managerial roles within this core identity. At the individual and group levels, interviewees demonstrated a strong sense of individuation and de-individuation through a process of accentuating differences between themselves and other groups, and similarities to the group with which they felt they identified most closely – their professional group. Numerous examples were offered through which interviewees believed they were acting as prototypical members of the midwifery group, all of which were inextricably linked with a commitment to their salient core identity, conceptualised as 'I am still a midwife'. The principal mechanism applied by the interviewees related to their belief that their current role activity was guided by the same philosophy as clinical midwives: women and their families at the centre of every decision.

8.3.3 Shared Language and Meanings?

As I mentioned in the earlier discussion of challenges to maintenance of a clinical identity, interviewees asserted their continued midwifery identification in relation to a shared language and history, which supports role identity theory's original assertion that society provides shared language and meanings, and further, that behaviour is premised on the meanings of names and terms (Stryker, 1968).

At the individual level, interviewees believed they behaved according to the identity labelled 'midwife', and that they shared a meaning and language of midwifery with their clinical colleagues. Findings from the study exemplified this belief: midwifery leaders reported 'doing' midwifery, just on a bigger scale or in a different arena. Again, such assertions related to the central theme of 'I am still a midwife'. The interviewees spoke of their behaviour being in keeping with the meaning of 'midwife', even when undertaking a management role, because the philosophy of midwifery acted as a guide in all that they did. As described earlier, they saw midwifery as a role that could be expanded far beyond clinical practice, encompassing such areas as management, leadership, education and research. Thus, in describing a transition from clinical to leadership or management role, the salient identity remained constant, and transition occurred within this identity. This was further exemplified in assertions of continued credibility, as a clinical role was considered only one element of the midwife role identity – credibility was maintained through emphasising their professional history, and through the employment of midwifery ideals in their current role.

However, at the professional group level, there was a divergence from this idea of shared language. From the perspective of the online respondents, moving into a role that did not include a significant (although undefined) clinical element was seen as a transition away from the midwife identity. Within the clinically-based group – identified in the online interaction and during observation of the band 6/7 leadership programme – the managerial

role was treated unequivocally as 'other', a theme reflected in the negative comments associated with discussions of the definition of 'matron', for example.

The idea of whether language is shared can also be explored in relation to beliefs about the 'manager' identity. As discussed above, interviewees described a management element as part of the expanded midwifery definition, and believed their clinically-based past meant they were well-placed to operate as hybrid clinical leaders, acting at the intersection of the business and practice of health (Kippist & Fitzgerald, 2009).

A very different understanding of 'management' was perceived by the online respondents, with managers conceptualised as uncaring, bureaucratic pen-pushers. Online respondents' attitudes towards managers who were formerly clinicians were especially scathing, based on ideas related to motives for going into such roles, and assumptions about ex-clinical managers having 'forgotten' the stresses of clinical life. Clinicians' understanding of management was based to a large degree on a lack of exposure to the relevant organisational structures, according to the LMS interviewees, an idea supported by their own reflections on prejudices they had similarly held as junior midwives.

Issues of shared language and meaning were highly relevant in relation to the theme, 'I am still a midwife'. By demonstrating that clinicians and service leaders held different conceptualisations of both 'midwife' and 'manager', the study findings challenge the idea put forward by Stryker (1968), that society provides shared language and meanings. The impact of this disconnect was evident in relation to the idea that behaviours are premised on the meanings of names and terms, as this lack of shared language was the root of identity conflict seen in the study – which, as I have shown, occurred at the group rather than the individual level. The study findings are more in keeping with Burke's idea (Stets & Burke, 2003) that different individuals may attach different meanings to the same role identity. The issue here still comes back to the significance of shared meanings, however.

In Burke's model of socio-cognitive systems and identity maintenance processes (Desrochers *et al*, 2002), behaviour is arrived at through a comparison between internalised identity standards and perceptions of self-relevant meaning, the comparison resulting in either verification of the identity or indication of a discrepancy (Stryker & Burke, 2000). In order to maintain verification of the midwife identity according to their behaviour in a clinical leadership role, interviewees went through a process of incorporation, which enabled them to verify that their current identity was still congruent with their professional identification. As Burke suggests (Stets & Burke, 2003), the incorporation process enabled a continuation of role behaviours among the interviewees, which is similar to Hotho's (2008) study, where doctors in clinical leadership roles created a 'hybrid professionalisation' – a new in-group, where boundary-spanning was seen as being *within* the identity of the group. In the LMS programme, this was demonstrated in the formation of new networks among clinical leaders, with associated descriptions of the value of building a supportive group, in which they were able to continue to self-identify as midwives, but all the group members experienced the expanded role identity.

The organisation was also involved in the debate around meanings and language, as highlighted in the first section of this chapter, in relation to a conflict between rhetoric and reality. The study findings offered a number of examples of this dissonance:

- The SHA involved in developing the LMS programme described the central role of talent management in the process. However, after the programme it appeared that the rhetoric of talent management (DH, 2009) did not match the reality of clinical leaders' experiences, with a reported sense of disappointment at the lack of continued development;
- Transformational leadership was embraced in the design of the programme, and interviewees came back to practice keen to enact learning within their leadership

role. However, the reality of life in the workplace made a transformational model difficult to enact, with clinical leaders continuing to operate within a transactional model of leadership, which was firmly embedded within the organisation;

- The meaning of ‘midwife’ appeared poorly understood at organisational level, which was seen in comments from the former chief executive, and in interviewees’ attitudes to the expanded HoM role as evidence of poor understanding and lack of acknowledgement of the midwifery role. Once again, there was a disconnect between rhetoric and reality in relation to government-level policy (DH, 2008), which appears to support a clearly-defined midwifery leadership identity, compared with the poor definition experienced by midwives.

8.3.4 Narrative Identity and the Challenges of Role Transition

In the theoretical framework for this study, I described the importance of narratives in role identity construction, in which two main points were raised:

1. Individuals construct and reconstruct narratives throughout their lives, through the use of identity work, as a means of making sense of their various identity transitions and enabling a coherent life or career narrative to emerge (Gendron & Spira, 2010; Somers, 1994);
2. Context, both temporal and spatial, is highly significant in narrative constructions, acting as both enabler of and constraint to the construction of individuals’ narrative identities (Watson, 2009; Humphreys & Brown, 2002).

These points were both seen in the interviewees’ descriptions of their career journeys. First, the interviews included significant attention to the maintenance of a coherent narrative, as midwifery clinical leaders told stories of role transition which always related to their over-arching assertion of ‘still being a midwife’. This identity was highly salient to the

interviewees, and they did not describe any difficulty in fitting their career narrative into this self-description.

The second point, however, was seen to be more problematic and complex. While the interviewees attempted to construct a cohesive identity narrative, they were operating within a conflicted environment. Within their professional group, as seen in the findings from the online interaction, the dominant discourse relates to clinical credibility and identity validation. Here, a reduction or cessation in time spent in clinical practice results in a loss of credibility within the professional group. Interviewees described the struggle to maintain this credibility, but at the same time tried to negotiate a novel role identity, in which their self-definition as a midwife was based on their distance from non-clinical managers (Snow & Anderson, 1987), and they carved out a role based on their continued professional group identification.

Within the organisational context, meanwhile, interviewees faced a further discourse challenge. Here, they were encouraged to embrace ideas of distributed leadership, which is the current NHS leadership discourse. However, as in all NHS clinical groups, and as described earlier, there is an apparent paradox in practice, with increased centralisation and governance inhibiting distributed or collective models of leadership (Martin & Learmonth, 2012; Currie *et al*, 2009; Currie & Lockett, 2011). Interviewees showed awareness of this discourse, in their resistance to the leadership programme's intention of establishing the next cohort of Heads of Midwifery in the region. In order to maintain their salient identity narrative (Spyridonidis *et al*, 2014), interviewees for the most part rejected the idea of continuing to a HoM role, as they considered it too far removed from the narrative they were constructing – one where they were still able to self-identify as 'midwife'.

8.3.5 Theoretical Conclusions

While many aspects of role and social identity theoretical principles were supported by the study findings, this was not universal. Role and social identity theories have much to offer to the analysis of identity construction and enactment in clinical leadership, particularly in relation to questions of commitment to role and social identity, self-categorisation and classification as means of simplifying potential role and social identity challenges, and individuation and de-individuation as means of maintaining a positive social identity.

However, the idea of shared languages and meanings, upon which behaviour is premised, is contested by the findings of this study. At the respective group levels, language and meanings were certainly shared, but between clinical and leadership groups there appeared a significant variance in meanings of terms such as 'midwife', 'management' and 'leadership', into which organisational structures added further complexity. These findings are significant in relation to the central theme identified in the narratives of the LMS interviewees, 'I am still a midwife'. In relation to future midwifery leadership, the study findings suggest a significant impact: clinical leaders asserted a continued midwifery identity, as they defined 'midwife', at individual and group levels of analysis. However, if this assertion is not validated or acknowledged by the professional group to which clinical leaders assign themselves, then identity conflict is seen at group level (Hogg & Abrams, 1988). There was a great deal of evidence to suggest this was the case within midwifery leadership. As the study findings described, identity conflict for the interviewees occurred at the level of the group: inter-group difficulties were seen in the challenge of working as hybrid clinical-managerial leaders, with midwifery leaders accentuating the differences between themselves and non-clinical managers. While the interviewees appeared able to incorporate management and leadership into their continued midwifery professional identification, the impact in terms of future midwifery leadership relates to the interviewees' expressed fear of moving too far away from the clinical area, as they believed there would be a threat to their self-identification as credible midwives.

Equally worrying for future leadership was the evident intra-group conflict arising from very different classifications of 'midwifery' and 'management'. Two significant themes can be identified from this conflict. First, there is a challenge to the enactment of clinical leadership, as clinically-based midwives understand clinical leaders to be 'managers', and there are negative connotations to this label in the NHS (Kings Fund, 2011). Second, if clinical leadership is labelled 'management', and management is seen as an unattractive career option due to its association with a loss of clinical credibility, then clinicians may be unwilling to take on any role identified as management, an analysis supported by the negative comments made by the online respondents. This analysis is strengthened by findings from both the LMS and the band 6/7 development programmes: in both cases, leadership and management roles associated with a loss of clinical credibility were considered unattractive. Further, clinical leadership studies in other areas have also highlighted clinical credibility as a key element in peer acceptance of clinical leaders (BMA, 2012; Osborne, 2011), and successful role enactment (Doolin, 2002).

Clearly, organisational structures have a part to play in this analysis. As described in the interviewees' narratives, a structured approach to development had been largely absent earlier in their careers, with the LMS programme being offered post hoc, given their relatively senior roles. The study findings echo the wider clinical leadership literature (Ham *et al*, 2010; BMA, 2012; Osborne, 2011; Phillips & Byrne, 2013), and are supported by role identity theory (Stryker & Burke, 2000; 2003), in suggestions of a strong interaction between individuals and organisational structures in leadership identity construction. While the interviewees described self-motivation and a desire to effect change in relation to career choices, these choices were made within the structure around them, and they required significant support at various points in their careers, for example through secondment opportunities, mentorship and coaching.

The study adds to a body of literature suggesting the value of applying principles from both role and social identity theories in the analysis of identity construction and enactment (Beech, 2011; Watson, 2009). Throughout the work, I have demonstrated that neither individual, professional group nor organisation works in isolation, and any single element is insufficient to explain questions of identity construction. Findings have supported the view that both 'me' and 'we' are of equal importance in transition to and enactment of clinical leadership in midwifery (Thoits & Virshup, 1999; Gecas & Burke, 1995), and that an approach which values the interaction between individual, group and organisation is better suited to addressing key concerns. In this case, the most obvious example of that interaction was seen in the issue of meanings and languages, where I concluded that the conflict between clinicians and clinical leaders was based almost entirely on a divergent understanding of what it means to be a midwife within a clinical leadership role.

The over-arching assertion, 'I am still a midwife', clearly holds at individual level, but is a much more contested theme among clinical midwives in the way they assess the identity of clinical leaders. The organisation also has a role to play in supporting this assertion of identity, if clinical leadership is to be successfully embedded within the NHS, but at present, from the experiences of the LMS interviewees, the organisation appears not to acknowledge or recognise the specific identity of midwives, seeing them instead as a branch of nursing.

8.4 A Return to the Research Questions

Having offered a discussion of the study's findings, I now return to a consideration of the research questions. The first question addressed the 'how' of midwives making the transition to leadership roles. It is clear from the analysis and discussion of findings that from an individual perspective, interviewees described the transition to leadership in terms of 'transition *within*' the midwifery role and social identity. This was demonstrated through

their universally-described conviction that they remained committed to their midwife role identity, no matter what leadership or management role they took on. Their self-definition was challenged at the professional group level by a contested view of identity transition, with online respondents perceiving the move to leadership roles as 'transition *away from*' the midwifery identity. This perception was based on a different understanding of leadership roles, which were instead conceptualised as 'management', with associated negative connotations. A further challenge was offered through organisation-level lack of understanding of the midwife role identity, with 'midwife' conceptualised more as a branch of nursing than as a profession in its own right, and consequent difficulties for midwifery leaders in considering the HoM role, as it had become expanded and, as the interviewees described it, unattractive.

The study findings demonstrated interaction between individuals, professional group and organisational structures in leadership identity construction and enactment in the case of midwives. This analysis was supported by employing principles of role and social identity theories. As recent papers have suggested, neither 'me' nor 'we' takes primacy in identity construction (Beech, 2011; Terry, Hogg & White, 1999; Sluss & Ashforth, 2007; Thoits & Virshup, 1999), and the study findings demonstrated this interplay at work throughout the process of a clinical leader identity construction.

From the perspective of narratives, identity work and role transition, the study findings showed a sense of complex interweaving narratives and relationships, in which midwifery leaders struggled to maintain their most salient narrative of the professional group identification. Identity work was necessary in the face of threats to this identity, from both within and beyond the professional group, and in the context of a paradoxical approach to leadership in the NHS.

The second research question addressed the development needs of midwives. Here, the study findings suggested that midwifery leaders had had highly variable development opportunities in their career journeys, echoing findings from the wider clinical leadership literature. In discussing the issue of development, it is important once again to address individual, professional group and organisational perspectives, and the next section turns to this area.

8.5 Liminality

The next section of the discussion introduces the idea of liminality in relation to transition from a clinical to a leadership role. I begin with a reflection to explain how an exploration of liminality came to be in the study, and then move on to explore how the concept can be applied to the study findings.

A New Idea

At the beginning of the third year of this PhD study, I had a conversation with one of my academic supervisors. I had just undertaken my completion review, and we were discussing where I thought my future career might lie. At the time, I was unsure about whether I would stay in academia, and if I did, where I might be best situated. We talked about this strange time of being a PhD student, where I was struggling to define myself according to a midwife identity, but did not really have any clear idea of what might happen when the PhD was completed.

Just a casual reference: liminal space. My supervisor suggested I had been in this liminal space during the PhD process, and at some point I would move on. I had no idea what he meant, and I remember scribbling the word 'liminal' down so that I could go and look it

up later. Then I remembered the word had come up at some point in a previous discussion with my supervisor, and I hunted out the reference. It related to the interviewees' descriptions of their time away from the frontline, and the luxurious feeling they associated with days spent at the LMS programme and the hours in coaching sessions.

Since then, I have spent a good deal of time discussing the concept, both in relation to the interviewees' narratives, and my own experience of identity transition. Sometime after those initial discussions in supervision, I gave a presentation at Warwick, on the subject of doing a PhD in the guise of what the university might consider an atypical student, at the request of my colleagues in the Research Exchange. The subject of my liminal existence came up in this presentation, and I was asked several questions about how it felt, whether I thought I should develop some sort of career plan, what did I think the other side of the threshold might look like...

Then, I started to explore the study findings more closely in relation to liminality, and the next section is the result of the exploration.

8.5.1 The Concept of Liminal Space

Van Gennep (1909; 1960) introduced the concept of liminality within the field of anthropology. Describing rites of passage, such as adolescence or pregnancy, van Gennep identified three stages in the transition from one state to another – so in relation to adolescence, a transition from childhood to adulthood:

1. Separation: the initiate is stripped of social status already held;
2. The liminal period: the period of transition;

3. Re-assimilation: the initiate is given his or her new status.

Beech (2011) describes van Gennep's conceptualisation of liminality as ritualistic – it begins with a 'triggering event', and the liminal period is then conducted in specific places for specific periods of time, and with associated rules of conduct. When the individual re-enters society in the new state, there are celebratory rituals associated with the event.

Turner (1967; 1969) took van Gennep's idea and focused on the liminal stage. During this phase of being 'betwixt and between', the individual is structurally, if not physically, invisible. Beech (2011) offers his own definition of liminality, describing it as

“a reconstruction of identity (in which the sense of self is significantly disrupted) in such a way that the new identity is meaningful for the individual and their community”.

Ibarra (2007) describes how a liminal period offers the opportunity for individuals to explore possible selves, and in this time there is a process of buffering of the individual: fewer rules and obligations are in place, and this encourages the emergence of new, tentative selves. The key theme in much of the literature around ideas of liminality relates to the idea of individuals being 'in between' identities, neither who they used to be, nor who they are becoming (Shinoda-Bolen, 2004). While there is some sense of individuals being weakened during these times, since they have no control over others, they are also liberated from the usual structural obligations, and thus in an area where creativity and exploration can be fostered (Czarniawska & Mazza, 2003).

8.5.2 Liminality in Leadership Development

This study has had at its centre a focus on identity construction and enactment, in the context of clinical leadership in the NHS. Through observation of leadership development programmes, and narrative interviews with midwives undergoing this development, I have

been able to explore the question of why, when and how midwives make the transition from clinical practitioner to clinical leader. While the interviewees have described this transition very much in terms of transition *within* identity, there has clearly been a sense of moving from one understanding of the midwife identity to another – from a narrow perspective, in which the core of the identity lies in hands-on activity, to a broader view of the profession, in which the midwifery identity includes supervision, leadership, management, education, and research. During observation of leadership programmes, I heard participants speak on many occasions of the pleasure of having time and space for self-development, and in interviews they described the development opportunities gained through secondment roles and the chance to have one-to-one coaching.

For these reasons, ideas of liminality are of interest in the study, and in the next part of the discussion I explore the experiences described by LMS participants in relation to development opportunities, within the context of literature on liminality in identity transition and construction.

In its simplest conceptualisation, the anthropological model can be applied to identity transition in leadership, as described by the LMS interviewees. Figure 8.1, below, shows the stages of transition according to van Gennep's model, with examples of how each of the three stages is delineated in midwifery leadership identity construction.

Figure 8.1 Liminality in midwifery leadership transitions



In the first stage, 'separation', the LMS interviewees described how they had to leave some part of their clinical identity when they moved into leadership and management roles. They described this as 'leaving the gang', and believed the process happened around band 7, an idea supported by Park & Hatmakes (2013), who write of the necessity of a re-socialisation process for managers moving into new positions of responsibility. While the interviewees acknowledged a separation from the clinical group to some degree, based on new responsibilities, they believed they retained a core 'midwife' identity, as described in detail earlier in this chapter. Ibarra (2007) relates this separation to ideas of push and pull forces: individuals realise the need for change in the face of *push* forces, for example through job dissatisfaction or reduced prospects; and *pull* forces, for example by seeing appealing alternatives. This idea was reflected in the interviewees' narratives, where they generally described a sense of looking for the next challenge or opportunity.

The second phase, 'transition', relates to interviewees' descriptions of and feelings about development opportunities. As described in the introduction to liminality, this phase has

been associated with a sense of freedom and creativity (Czarniawska & Mazza, 2003). Ibarra (2007) suggests there is particular emphasis on a sense of freedom in opportunities such as sabbaticals or educational programmes. In these cases, there are temporal boundaries, which Ibarra relates to a suspension of rules, and during which time individuals are able to “toy safely with possibilities”.

This was a significant theme in the interviewees’ descriptions of coaching, leadership programmes and secondment opportunities. For example, coaching was seen as a time to gain a tailored insight into future possibilities and make plans for next career moves, while secondments gave interviewees the chance to ‘try out’ a new role, in the knowledge that such opportunities were time-bounded and held no obligation for them to take on the role permanently. Meanwhile, the LMS programme was described in terms of ‘space’, and ‘time away from the coalface’, during which interviewees were able to interact with other midwifery leaders, and consider whether they might want to take on more senior roles as a result of the insight they were gaining into their own strengths and weaknesses. These examples support ideas of “curiosity, exploration and even frivolity” (Ibarra, 2007), and give credence to the idea expressed by Park & Hatmakes (2013), that other relevant individuals are important sources of individuals’ own behavioural decisions and development, particularly when new in post.

During the LMS programme, interviewees were particularly enthusiastic about the opportunity to develop a peer group network, and the importance of this is described by Park & Hatmakes (2013) in relation to managers’ sense of isolation, particularly when the role is new. This idea is supported in an observation made during the senior midwife leadership programme in the East of England, where I listened to a conversation between a group of heads of midwifery, who were discussing how they suddenly realised how alone they had felt, now that they had gained a supportive peer network.

The third phase, 're-assimilation', was where problems lay in relation to liminality and leadership development in this study. Van Gennep's model suggests a ritualistic approach to this phase (Beech, 2011), with organised celebrations to announce the arrival of an individual who has successfully crossed the threshold. For the interviewees, this element was not in evidence beyond the LMS programme itself. At the end of the programme, there was a celebration event, as there was at the East of England programmes. I was able to attend each of these events, and there was a clear sense of having made a transition during the leadership programmes. Participants engaged in activities such as presentations of work they had undertaken as part of the programme of development, and offered reflections on what they had learned during their time of development. There were whole group activities involving the making of music, designed to engender a sense of oneness within the group. Here then, the celebratory nature of the re-assimilation phase was highly evident.

However, as I described in relation to a sense of disappointment and disillusionment, at the organisational level there was no recognition of the interviewees having crossed a threshold, which is likely to have been connected to the fact that the LMS programme was supported at SHA level, rather than via NHS trusts. Whatever the reason, the result was a sense of returning to the frontline where nothing had changed, and ultimately interviewees described how the momentum and enthusiasm they had developed during the leadership programme was becoming difficult to sustain.

The other issue in terms of crossing a threshold lies in the interviewees' return to a role they already held. As I described earlier, development generally came at a time in their career where they had been in leadership roles for a number of years, and so the idea of crossing a threshold becomes less obvious. Notable here is Pauline's narrative, as she was the exception to the general picture: in her case, she had worked as a band 6 and

subsequently band 7 midwife in the community setting for many years, but shortly before the LMS programme she had spent ten months seconded to a matron role. At the time of the programme, she had just gained a substantive matron role, and her narrative was full of a sense of having made a significant and unexpected transition – and in her case, there was gratitude for the timing of LMS, as it came at a time when she felt she was indeed crossing a threshold into senior leadership.

In terms of narrating their identity, then, liminality speaks to the idea that ‘provisional selves’ (Ibarra, 1999) and the possibility of ‘trying out’ new identities (Ibarra, 2007) was a significant part of the interviewees’ identity work during a perceived transition period. However, because there was a lack of structure to the re-assimilation part of the liminal process, and because of the dominant professional group narrative, interviewees then struggled to incorporate these new identities into their career narratives. Instead, as I described earlier, their narratives stopped short of ‘crossing the threshold’ if the interviewees considered new role identities too far removed from that available in the contextual discourses within which they were operating.

8.5.3 Liminality as Supportive Structure

The interviewees described leadership development opportunities in terms of liminality: space away from the frontline, time to consider possible futures, the ability to ‘try out’ potential leadership roles. However, the third stage of the liminal process, that of re-assimilation, was less apparent in the interviewees’ narratives.

Given everything written in this discussion chapter on the subject of challenges to clinical leader identity and the difficulty in maintaining the assertion, ‘I am still a midwife’, it is interesting to consider whether liminality might be a useful concept in improving the current provision of development in clinical leadership. As the wider literature suggests,

liminality offers the potential for recognition of the important transition undertaken in a move to management roles (Park & Hatmakes, 2013; Ibarra, 2007; Hekman *et al*, 2009), and this can be explored at individual, group and organisational levels, in keeping with the general approach taken within the study:

- At the individual level, a liminal or 'rite of passage' approach to development helps individuals make a transition to leadership a recognisable 'process'. The opportunity for time and space at the threshold, during which individuals are able to learn what the other side looks like, was found to be beneficial to the LMS interviewees. However, given that this is essentially a period of uncertainty and exploration, structural and peer group support is necessary at this time;
- At the group level, a transition to leadership becomes a recognisable part of organisational progression. Peers are able to support liminars in their transition to a leadership role, and the process becomes more visible – with the possibility of reducing the negative perception of those who move to leadership and management roles. As the interviewees suggested, many of the prejudices held by clinical midwives about leadership and management are based on the fact that they have little awareness of the mechanisms and processes of career development;
- At the organisational level, a structured process that incorporates all three parts of the transition would support individuals in moving from clinical to leadership roles. By making liminal space a recognisable and acceptable part of the leadership development process, individual leaders gain a sense of organisational level support. In order for this to be embedded within the organisation, there would need to be a commitment to continue to support clinical leaders in their new roles, and development would need to be undertaken in a timely and appropriate manner, something that has been lacking within the NHS model of leadership.

From a narrative identity perspective, liminal space – whether in the form of secondment opportunities, development programmes, mentorship, or coaching - offers individuals the chance to supportively negotiate available discourses, giving them the opportunity to add or discard narrative identities as they find necessary. However, in order for new identity narratives to be successfully incorporated into an individual's broader career narrative, there is always the necessity for structural support and professional group acceptance and validation.

8.5.4 Conclusions

In this part of the discussion, I have explored how ideas of liminality have played a part in the leadership narratives of the LMS interviewees, albeit in a post hoc fashion. The three phases of liminality as a rite of passage were examined in the context of relevant literature, and in relation to the experiences of the interviewees, and there was found to be a degree of complexity associated with the third phase, due to the de-contextualised nature of the LMS programme and the career stages of those undertaking the programme. Pauline's case was highlighted as a positive indicator of the future possibilities around introduction of liminality as a structured model of leadership development, as she exemplified how the model might be usefully applied at a point when individuals are in the process of moving into new leadership roles.

In summary, the idea of incorporating liminality within NHS leadership development structures can be described in relation to individuals, professional groups and the wider organisation. While the LMS interviewees described in positive terms the opportunities inherent in situations that might be described as liminal spaces, they faced significant challenges on their return to the workplace. There was a perceived lack of support from the organisational structures in enacting transformational models of change leadership, and the interviewees struggled to maintain their motivation and enthusiasm in the face of

no further development. While there has been criticism of a decontextualized approach to leadership development (Phillips & Byrne, 2013), the opportunity for development away from the workplace was considered highly attractive by the LMS interviewees. Perhaps the issue is more to do with bringing learning back to the workplace, as described in this study, rather than learning that takes place in a separate arena being inherently undesirable, with the organisation needing to adopt an ongoing supportive approach, rather than short term interventions. Also at the individual level, interviewees expressed disappointment that they had not been offered such development opportunities earlier in their careers, as for the most part they had followed the unstructured path described in the wider clinical leadership literature. A liminal space model of development would answer this concern, if it were introduced at the appropriate point in clinicians' careers as opposed to the often post hoc approach seen in the NHS generally (BMA, 2012; Osborne, 2011; Phillips & Byrne, 2013). Further, the study has identified significant problems at the intra-group level of clinical leadership, demonstrated through the strong counter-narrative produced in the online interaction, which provided a far more negative view of why and how midwives make a transition to clinical leadership roles. A structured approach to leadership development, through which clinicians were able to see their colleagues making definite and considered moves to leadership, in a supportive and structured environment, might go some way to altering the prejudiced view currently held by clinical midwives on the subject of clinical leadership. As the study findings suggest, current NHS structures appear to offer the possibility for exploration of possible selves, but the reality in the workplace do not support this positive discourse. As described in narrative identity theory, role transition is a complex process of negotiation and identity work, and the interviewees' struggles to establish a cohesive, coherent, validated narrative is evidence of this complexity.

8.6 Unexpected Findings

I return now to my initial observations of midwifery leadership and management, described in the introduction to this thesis. As a student midwife, I repeatedly heard the dominant narrative of midwifery leaders as managers, where managers were intent on making clinical life difficult, and management was a distant phenomenon in the organisation, far removed from the challenges of everyday life at the frontline. I fell into the trap of thinking that if leaders and managers were not visible and accessible, then they were not part of the midwifery workforce.

As a qualified midwife, I continued to hear this narrative, but was aware of service leaders who did not fulfil this negative stereotype of 'the management', in which managers were depicted as faceless, uncaring, obstructive pen pushers. However, the idea that midwives became managers because they no longer wished to work clinically, or because they had to be given something other than clinical work to do due to poor practice, certainly meant I expected to find stories of accidental leadership among the study's interviewees.

This was my first surprise: rather than narratives of accidental leadership, I discovered passionate individuals who fully believed they continued to behave as midwives, and who had made definite career choices along the path to leadership. While there was often a sense of being in the right place at the right time, there was an underlying self-motivation at play, closely linked to the idea that they always 'sort of knew' they wanted to do more than hands-on practice as midwives. They described having been interested in effecting change, or always having been seen as particularly challenging members of staff. Listening to their narratives, my assumptions were challenged, but I did not find my former clinical colleagues so convinced of these stories of focused careers.

This was my second surprise: the strength of feeling against 'managers' evident in the online interaction. I had expected some negative feeling, given my own experiences in clinical life, but the derogatory terms respondents used to describe matrons and others they considered management did surprise me.

My final surprise lay in the discovery, during the second round of interviews, that LMS delegates had largely decided that they would not want to move on to a HoM role. Having met with such enthusiasm and high levels of motivation in the first interviews, I was somewhat taken aback by the alteration in career aspirations encountered in later interviews.

8.7 Study Limitations

In this study, I worked to ensure rigour through a process of systematic and self-conscious research design, data collection, analysis and interpretation (Mays & Pope, 1995). I used Bloomberg and Volpe's (2008) criteria of credibility, dependability and transferability and added Lincoln & Guba's (1985) idea of confirmability, in order to ensure the trustworthiness of the research. Several elements were addressed through this approach:

- **Credibility:** I attempted to ensure my portrayal of the interviewees matched their own perceptions of the interactions. To do this, I sent transcripts, themes and narratives to the interviewees, and asked whether they thought I was offering an accurate representation of them. In particular, the later interviews were used partially to discuss emergent themes, so that I could be sure I was not building these out of my own thoughts rather than what the interviewees had said; similarly, on the online forum, I regularly checked respondents' comments through a process of interaction, again to ensure that I was not projecting my own assumptions onto their counter-narratives;

- Dependability: I ensured that processes and procedures of data collection and interpretation could be tracked throughout the study. All field notes and transcripts were and are available for review, and findings were consistently checked with academic supervisors. Analysis stages were carefully recorded in hand-written research diaries;
- Transferability: I worked to ensure that the reader would be able to decide whether similar processes might be at work in their setting, through clear documentation of all research processes and through a detailed description of the design and execution of the study;
- Confirmability: to ensure that findings were clearly derived from the data, I demonstrated the process of analysis throughout the study, and have described the analytic stages from data collection to representation. Again, very detailed notes were kept throughout the process.

However, in any study there are likely to be limitations, particularly when the researcher is an explicit data collection and analysis instrument. In this case, I have been explicit in my reflexive and reflective approach, and the text boxes and reflective accounts running through the thesis are evidence of this. While it might be suggested that there are conflicts to be found in my dual identity as researcher and member of the professional group I chose to study, I believe this concern can be answered in three ways:

- I undertook the research process according to the principles noted above, and was guided throughout by my academic supervisors and my previous education to masters level in research methods;
- I employed the reflective approach I had been taught as a student midwife, and worked hard to constantly question my own assumptions. This is demonstrated in the earlier section in which I detailed surprising results from the study;

- I engaged with friends and former colleagues throughout the research process. As I have described in earlier chapters, this was not always a comfortable process, but it enabled me to examine the question of identity construction in midwifery leadership from a number of different angles, and challenged me in relation to underlying assumptions based on my own clinical background.

There are two other limitations to the study, both related to the participants. First, the interviewee sample size was small. This was partly due to difficulties in gaining access to other leadership programmes, but in fact the interviews were remarkably similar in their emergent themes. I could have gone on collecting data for longer, but felt that it was important to move on and explore the other side of the leadership narrative, through engagement with the online forum. Additionally, my long period in the field, undertaking observation of several leadership programmes, enabled me to ensure that I was not missing other narratives, as I used observation opportunities to explore themes as they arose.

The second limitation relates to the nature of working with an online forum. At the Midwifery Sanctuary, there is considerable passion and frustration in evidence, as demonstrated in the strong counter-narrative described in the study. It might be suggested that this is an example of 'groupthink' (Janis, 1972), where people who do not agree with the overriding opinion of the group tend to remain quiet, and thus would not be commenting in the debates I began. However, I employed a rigorous approach here, and discussed the forum views with service leaders and clinical midwives. I found a remarkable symmetry among clinical midwives with the views expressed by forum participants, which strengthened the data produced through this avenue.

In conclusion, the study may have limitations, as all studies do, but there have been particular strengths associated with my former clinical role, particularly in relation to the

communication style between me and the various groups of participants. Ironically, despite my not practising clinically for the duration of the study, participants seemed keen to identify me as a midwife, and offered me rich qualitative data on this basis. On my part, my reflective nature has ensured my continued self-scrutiny throughout the lifetime of the study, from initial study design to the writing up of findings, and I worked hard to make sure I was the best research instrument I could be.

8.8 Chapter Conclusions

In this chapter I have systematically discussed the study's findings in relation to the themes associated with challenges of clinical identity and to the study's theoretical framework. I have shown the constant interplay between clinical leaders as individuals, members of a challenging professional group, and employees within an organisation that appears to be continuing to struggle to match rhetoric with reality. The study's findings have highlighted the importance of both 'me' and 'we' in the development and enactment of clinical leadership in midwifery, and I have added a strong theoretical basis to explanations of challenges in clinical leadership identified in earlier studies in nursing and medicine. The place of narratives in role identity transitions has been employed to explain the complex identity work necessary for midwives making a transition to clinical leadership roles, with strongly dissonant discourses acting as challenges to their coherent and cohesive career narratives.

Finally, I introduced the idea of liminality in transition from clinical practitioner to clinical leader, and demonstrated how the concept of crossing a threshold might work to ensure support for clinical leaders at individual, group and organisational levels.

I referred to several unexpected findings, which challenged assumptions I might have held at the beginning of the research process, and I identified and addressed possible limitations to the study.

The final chapter will address the theoretical and contextual contribution of the study, and I will suggest possible areas for further research. I then complete my personal narrative in order to show how my own identity transition has been enacted, and I describe how I finally managed to cross a threshold at the end of this research process.

Chapter Nine: Conclusion

9.1 Introduction

In this study, I set out to answer several questions in relation to clinical leadership in the NHS. With recent Department of Health reports suggesting the importance of clinical leaders (DH, 2008; DH, 2009a), the following significant questions were identified:

1. Whether clinical leaders are in fact the ideal people to deliver the required changes;
2. How attractive clinical leadership roles are, and will be, to this and the next generation of clinicians;
3. What is the significance and impact of a professional identity on clinical leadership.

This chapter concludes the study, and within it I reflect on what has been discovered in relation to these issues. Specifically, I summarise the findings in relation to the overarching research questions, and assess the study's contribution in terms of the research gap identified at theoretical and contextual levels. I go on to discuss the implications of the knowledge gained through this study, and suggest further areas for future research based on the findings presented here.

9.2 The Path to Knowledge

In this research, two questions were presented in relation to the exploration of identity construction and enactment in clinical leadership:

1. How do exogenous and endogenous factors influence the transition to and enactment of leadership among midwives?
2. What are the development needs of midwives to promote new ways of working and drive system-wide change in the NHS and how might these be achieved?

In this section of the conclusion, I summarise the answers to these questions.

9.2.1 Endogenous factors in the transition to leadership

The career narratives of the LMS programme interviewees demonstrated the significance of endogenous factors in the path to leadership. The interviewees described the importance of self-motivation and inner drive. At times, they appeared less than confident, and in some cases appeared surprised to have found themselves in leadership roles relatively early in their careers – this was particularly evident in those who had taken a direct entry route into midwifery. For interviewees who had been in the NHS longer, there was evidence of long-term career planning, and a sense that they had taken deliberate steps along the way. Interviewees were motivated by a desire to effect strategic-level change in midwifery service provision, and described having wanted ‘more from midwifery’ than a hands-on role. They had generally sought out opportunities for career progression, albeit with the encouragement of significant individuals.

9.2.2 Exogenous factors in the transition to leadership

Factors influencing the LMS interviewees’ journeys to leadership were largely organisational or structural. Interventions such as leadership development programmes, coaching and secondment opportunities were highly significant, and received positively by the interviewees. However, such interventions had often happened when interviewees were already in a line management role, rather than before moving to such positions in the organisation. There was a place for ‘significant others’, such as mentors and role models, who were generally in a senior position within the organisation and who acted as guides on either a short-term or career-long basis.

9.2.3 Endogenous factors in the enactment of leadership

The most significant element in the enactment of leadership was the over-arching theme, 'I am still a midwife'. Interviewees described this as their guiding tenet, as they believed the principles of their professional identity were at the centre of all they were doing as leaders within the organisation. While interviewees believed they would carry this core identity throughout their careers, they did express a fear of losing some professional credibility, and were concerned it would become increasingly difficult to maintain their 'midwife' identity if they were to progress to a role they considered more managerial than professional.

9.2.4 Exogenous factors in the enactment of leadership

The professional group and the wider organisation were highly significant in the enactment of leadership in this study. The group perception of leaders as 'the management' was considered challenging, according to the LMS interviewees, and they invested considerable efforts in contesting this view. From the online respondents' perspective, midwives who no longer practised clinically were treated as 'other', as they were considered to have left the professional group. Here, the organisation was significant, in that interviewees described themselves as wanting some element of clinical practice time within their leadership role, but were unable to achieve this due to the time they were expected to spend in non-clinical activities. The organisation was also considered significant in relation to the lack of attraction to senior leadership roles, with a perceived lack of understanding of the midwife role identity, where the expansion of the HoM role was understood by interviewees as a demonstration of this lack of understanding.

9.2.5 Development needs of midwives

The experiences of midwifery service leaders were very much in keeping with the traditional model of NHS leadership development, where career structures have been

poorly articulated (BMA, 2012; Osborne, 2011) and lacking in organisational support (Ham *et al*, 2010; BMA, 2012). The interviewees described reaching leadership and management roles with little or no prior education, which they believed was far from ideal. Interviewees valued opportunities for development, both from an individual and a group perspective. At the individual level, their needs were for personalised, tailored opportunities for reflective learning, with one-to-one coaching considered particularly valuable. At the group level, interviewees valued the networking opportunities offered through attending the LMS programme. The most significant theme emerging in relation to development needs concerned the importance of continued organisational support for further development after the leadership programme had ended, as returning to the frontline was challenging, with delegates attempting to enact the transformational model of leadership taught on the programme but discovering a strongly transactional approach still in evidence.

What is evident throughout the findings, in relation to both research questions, is the constant interplay between individual, group and organisation in the transition to and enactment of a clinical leader identity. I now turn to the study's contribution to knowledge, in the light of these findings.

9.3 Contribution to Knowledge

In the introduction to the thesis, I described three areas where the study might offer a contribution to knowledge:

- An extension of ideas of identity transition and enactment through the evocation of role and social identity theories, and the interplay between these theoretical perspectives;
- An exploration of the challenges of clinical leadership in the NHS at a theoretical level;

- An examination of NHS leadership development and enactment thinking in the context of contemporary theory, centred on a distributed model of leadership.

In the following sections I address these themes, and present the study's contribution to theoretical and contextual knowledge.

9.3.1 Contribution to Theories of Identity

In chapter two, I introduced the theoretical framework underpinning the study, which related to role and social identity (Stryker, 1968; Tajfel, 1979). I described how, by applying an integrated approach, the research would be able to address the significance of both 'me' and 'we' in identity construction and enactment (Thoits & Virshup, 1999; Sluss & Ashforth, 2007; Terry, Hogg & White, 1999). This was based on criticisms of the individualistic focus often seen in the study of leadership (Gronn, 2002; Northouse, 2007; Horner, 1997), and a reflection of contemporary leadership thinking which has suggested the importance of a holistic approach, where individual leaders, follower groups and wider organisational structures are considered together in assessing leadership (Avolio *et al*, 2009; Yukl, 1999; Winkler, 2010).

I have presented findings from the study to illustrate the interaction between individuals, groups and organisation in clinical leadership within the NHS. As suggested in both contemporary leadership and identity thinking, no single element took primacy, and the process of clinical leadership was found to be complex and, at times, challenging due to this constant interplay between elements (Gecas & Burke, 1995; Smith, 2011; Fitzsimmons *et al*, 2011;).

As suggested by role identity theory (McCall Simmons, 1966; Burke & Reitzes, 1991), the LMS programme interviewees expressed commitment to their most salient identity, that of 'midwife'. Within this identity, they incorporated 'leader' and 'manager', and described a

transition to leadership *within* their core identity rather than away from it. They believed they continued to act according to their salient identity, giving many examples of how they achieved this, despite no longer practising clinically.

At the group level, the issue of clinical practice was central to the 'midwife' identity. While the interviewees believed their shared history and language was the element allowing them continued membership of the professional group, this was rejected by the online respondents in the study. From their perspective, midwives who no longer worked alongside them had made a transition *away* from the group identity, instead taking on that of 'manager'. The prejudices of clinicians in this study were largely based on a narrow view of the midwife identity, centred on the value of hands-on practice, a view contrasted with the wider perspective taken by the LMS interviewees, who were able to see that the midwife identity could be expanded to areas such as leadership, management, education and research. Exposure to wider roles appeared highly significant, with interviewees acknowledging that their own perceptions had been narrower when they themselves had been working as clinicians earlier in their careers.

As suggested in theories of identity (Ashforth & Mael, 1989; Hogg & Abrams, 1988; Stets & Burke, 2000), there was evidence of categorisation and classification running through the findings, the problem lying within the bases for category formation, which suggested language and meanings were perhaps *not* shared between or within groups. Here, the wider organisational structures played a central role, where interviewees described a lack of understanding at trust board level as to what 'midwife' might mean. This was further demonstrated at the group level, where 'midwife' and 'manager' held vastly different meanings for online respondents and interviewees, the consequences of which were intra-group conflict and rejection of clinical leaders by the professional group.

The study findings clearly demonstrate the value in approaching clinical leadership from both role and social identity perspectives. While much leadership analysis takes an individualistic approach, this study has demonstrated the significance of both professional group and organisational structures in the transition to and enactment of clinical leadership among midwives. The analysis presented in the study supports recent suggestions of the central interaction between 'me' and 'we' in identity construction (Gecas & Burke, 1995; Brewer, 1991; Thoits & Virshup, 1999), and offers a strong theoretical basis for suggesting that this complex interaction is at work in the construction and enactment of clinical leader identities.

The study's attention to the place of narratives in identity construction and enactment has added to the analysis at theoretical level. As suggested in narrative identity theory (e.g. Gendron & Spira, 2010; Humphreys & Brown, 2002; Somers, 1994), midwives' narratives of role transition were both enabled and constrained by surrounding discourses, both within their own professional group and beyond, in the wider organisational structures of the contemporary NHS.

9.3.2 Contextual Contribution

The NHS has recently been attempting to move away from its traditionally transactional, hierarchical, command-and-control model of leadership, towards a transformational, distributed approach (DH, 2008), a change that has been broadly welcomed (Millward & Bryan, 2005; Oliver, 2006; Ham, 2003). The move has been a reflection of contemporary leadership thinking, where leadership is conceptualised as a fluid, adaptive process of influence rather than a fixed set of traits, characteristics or behaviours (Uhl-Bien, 2006; Hartley & Benington, 2011; Turnbull James, 2011, Avolio *et al*, 2009). Contemporary organisations are seen as complex, with flattened structures and increased worker skills meaning a distributed model of leadership can and should be applied (Fitzsimmons *et al*,

2011), in which leadership is not seen as a unidirectional activity, but instead can be shared by different organisational members at various times and in various circumstances (Yukl, 1999; Turnbull James, 2011). Meanwhile, a transactional model alone is seen as ineffective and in fact, potentially damaging to employees and the organisation, while a transformational approach alone risks a return to the individualised focus so heavily criticised in the post-heroic paradigm (Boseman, 2008; Bass, 1990; Deckard, 2010).

This study has shown the challenge to the NHS of introducing contemporary leadership models. The LMS delegates were taught theories of transformational leadership for change implementation, and were enthusiastic about bringing this learning into practice. However, on their return to practice they encountered a transactional model in the workplace, and struggled to maintain their motivation and drive to effect change. There was added complexity in the way they were perceived by their clinician colleagues, with a rejection of their professional identity and assumptions that they were behaving as ‘the management’.

The challenge of matching the rhetoric of new models of leadership (DH, 2008) with the reality of the frontline was further demonstrated in the development experiences of the interviewees. The NHS has recently embraced the principles of a talent management approach to career development and succession planning (DH, 2009; NHS Employers, 2009), which on the surface would suggest equal commitment to individual careers and organisational structures. Talent management emphasises the interplay between individuals and organisation, and stresses the importance of continued development to ensure individuals are constantly offered opportunities to progress within the organisation (Clake & Winkler, 2006; Yarnall, 2009). The LMS interviewees had experienced the out-dated model of leadership development historically associated with the NHS, but the introduction of the LMS programme was explicitly based on a talent management

perspective, the idea being to develop individuals *within* the needs of the service, thus addressing questions of individual careers and organisational succession planning. However, while interviewees felt they had gained a great deal through attending the LMS programme, they experienced a more traditional problem on their return to practice, where they encountered a lack of continued support for their career development. The LMS programme was a short-term intervention designed to develop the next generation of HoMs, but with few positions becoming vacant, and a lack of follow-up by the SHA providing the programme, the talent management agenda appears not to have been met in this case.

In terms of context, then, the study identifies several significant issues, in relation to the questions I posed at the beginning of the chapter:

1. Clinical leaders are well-placed to deliver the required changes in the NHS, given their understanding of the organisation from both clinician and leader perspectives. However, they require support from general managers, with this study suggesting that midwifery leaders appreciate and welcome the skills offered by general managers. This supports the idea expressed by some authors (Ham *et al*, 2010; Hoff, 1999), that clinician/manager relationships are not so much about dichotomies, but rather concern the importance of both group valuing each other;
2. Leadership roles, in this study, were found to be unattractive if they were considered 'management'. This belief, from the perspective of the online respondents, stemmed from a belief that a loss of the hands-on role meant a move away from 'midwife', towards 'manager'. This was echoed to a degree by the interviewees, who feared a loss of their professional credibility if they moved too high in the organisation, specifically identifying the HoM role as problematic;

3. The professional identity is highly significant to clinical leaders. The study identified that midwifery leaders retain the identification of 'midwife' at the core of their current role. In some ways this is beneficial, given the value brought to clinical leadership roles by professional knowledge and history, but there may be negative connotations as well, with clinical leaders reluctant to move on to higher levels of leadership if they believe their professional identity will be threatened.

9.3.3 The Case of Midwives

From a midwifery perspective, this study offers an insight into issues facing the profession in relation to leadership. There has been a great deal of attention on the profession in recent years, on the basis of several damning reports into maternity services failures (HCC, 2006; 2004; Fieldin, Richens & Calder, 2010), and concerns about the ageing workforce profile (DH, 2010). The LMS programme was designed to prepare a cohort of midwives to be 'ready now' for senior leadership roles, particularly at HoM level. However, by the time of the second interviews, I found a group of midwives who did not find the prospect of further career progression as attractive as the programme providers might have hoped. As already described, there was a sense of disappointment in the lack of continued support from the SHA, and the challenge of enacting transformational learning in an organisation operating largely within a transactional model of leadership.

The most significant aspect of this study, in relation to midwives, was the discovery of a chasm between clinicians and clinical leaders. While the profession has traditionally faced threats to its identity from beyond, particularly in relation to a lack of differentiation from nursing and a subsuming within obstetrics (Ralston, 2005), it also appears to be challenged by intra-group conflict. This has been hinted at before (Kirkham, 1999; Ball *et al*, 2003; 2006; Curtis *et al*, 2002), but this study is the first to explore the midwifery leadership narrative from both sides of the chasm, an exploration underpinned by a theoretical

framework supportive of multiple layers influencing leadership identity construction. The problems highlighted in the context of midwives are significant within the profession, but can also be viewed as exemplary of the wider organisation.

Issues of intra-group conflict are not limited to midwives within the NHS. As described in previous literature on the subject of clinical leadership in nursing and medicine, the question of clinical credibility and acceptance or rejection by the professional group has also been identified in these professions (BMA, 2012; Osborne, 2011, Hoff, 1999). Midwives provide further evidence of this conflict, but the theoretical strength of this study offers a deeper insight into the problem, which is one concerned with individual clinical leaders, professional group understandings and prejudices, and organisational support and commitment. By adopting a perspective which explores the impact of 'me' and 'we' in midwifery leadership, issues have been explored that can be extrapolated throughout the NHS as a whole.

9.3.4 Implications of New Knowledge

The study has added a theoretical underpinning to the field of NHS clinical leadership, in which various challenges have already been identified. The significance of a continued professional identification from the individual leaders' perspectives is important for future organisational succession planning and leadership development. Clinical leaders retain a professional identification; this is not to suggest that they reject an organisational identification, nor that they are insufficiently committed to the organisation, but it does emphasise the importance of the NHS understanding the significance of this professional identification. From the group perspective this is extremely important, as clinical midwives did not recognise the professional identification expressed by the LMS interviewees. Because of this disconnect between perceptions of clinicians and clinical leaders, there are implications for future leadership which must be addressed within the wider organisation:

- The intra-group conflict has implications for the enactment of leadership. Clinicians are likely to resist changes they feel are imposed on them by 'the management', and clinical leaders struggle to retain the professional group membership associated with a positive social identity;
- Clinical leaders fail to see the attraction in leadership roles which they perceive as risky in terms of a continued professional identification;
- Clinicians find leadership roles unattractive if they perceive them to be managerial in nature, as they believe they will be expected to move away from their professional identification.

The introduction of a liminality model suggested in the discussion chapter may be one way of addressing the problems of clinical leadership in the NHS. By adopting an approach which explicitly recognises the transition involved in moving from clinician to clinical leadership roles, I suggest benefits at all three levels of analysis: individual, professional group and organisational structure. Thus, there is recognition of the highly significant interplay between 'me' and 'we' in the construction and enactment of a clinical leadership identity in the NHS.

9.4 Practical Implications

The study has a number of practical implications, which can be discussed in relation to various interested groups:

- Within the midwifery profession, concerns have already been highlighted in relation to succession planning and achieving effective leadership. The study highlights the imperative for the profession to extend its discourse of 'midwife' if future leaders are to be enabled to take on clinical leadership roles, which will help to lead the profession forward and establish the desired board-level effective

presence. The multi-vocal profession needs to endorse roles that are not necessarily clinically-based, meaning that those in leadership and management roles are seen as valid and valued members of the professional group;

- The NHS has focused a great deal on the development of leaders in the recent past, in order to fulfil its desired move towards a distributed, collective model of leadership. However, the study found further evidence of dislocated, individualised programmes of development for leaders, and competing discourses of leadership and governance in practice. If the NHS agenda is one of leadership at every level, then this study adds weight to arguments that development should take place within that context. At present, the study suggests, professional groups are not necessarily buying into the discourse of 'leadership for all', with online respondents clearly articulating the belief that 'leadership' is in fact 'management', with all the negative connotations associated with that definition;
- Within leadership development and talent management agendas, the idea of liminal space can be viewed as a positive means of managing the complex role transitions inherent in a multi-professional organisation. However, as the study findings suggest, the provision of liminal space needs to be followed up with a continued structured approach to career development and progression. As the talent management literature suggests, it is not enough to remove individuals from their context for development; rather, continued structural support was identified as a 'missing link' by midwives in this study, and the consequences of this are worrying for the profession, with a subsequent resistance of taking on further leadership roles;
- Finally, the study suggests that leadership development needs to be visible and available to all members of a professional group, and if talent management approaches are to be fully inclusive (as the NHS suggests in its rhetoric on the

subject), then explorations of possible selves and new narratives must be made available within the organisational context.

9.5 Areas for Future Research

The study has demonstrated the significance of the professional identity in NHS clinical leadership, for clinicians and clinical leaders alike. The conflict identified in the case of midwives suggests a divide between the groups in relation to the meaning of 'midwife' and 'manager' or 'leader'. Findings support the important role played by wider structures, with suggestions of a lack of understanding of the unique professional identity of midwifery, which has implications for the future of leadership at professional group and organisational levels. Future research could address this issue, with an exploration of trust-level conceptualisations of 'midwife', which is necessary if the profession is to gain the strong, effective leadership it so clearly needs.

From the perspective of clinical leadership in the NHS more generally, implementation of the liminal model would make an interesting area for future research. Here, there might be analysis of whether this model holds the potential to alter perceptions of clinicians in relation to understanding the motivation of those deciding to move to leadership and management roles.

From an organisational perspective, future work could focus on addressing the challenge of integrating transformational and transactional leadership models, given that both have been suggested as necessary within the organisation. This study highlighted the challenge of enacting transformational leadership in the NHS, with the organisational rhetoric on the subject not being well-matched to life at the frontline.

Final Thoughts

I have loved this process. I have been challenged, I have had to think far beyond my comfort zone, I have had to justify every decision I made, I have been situated in a new environment, and at times I have felt anchorless and rudderless. As I said at the beginning of the thesis, I have never had such luxury before. But neither have I had four such challenging years before.

This thesis has concerned identity transition, and as I have intimated at various points in the work, I have been travelling a strange road myself, during the process. Perhaps I have a tendency to over-think such things (definitely I have), but there have been many parallels between the narratives of the LMS interviewees and my own. Having left the structured, exhausting, emotional world of the clinical midwife in order to undertake this study, it is interesting (I hope) to end the thesis with where the road has taken me.

Well, my funding ended in September 2012, and I had to consider what to do next. Happily, one of my supervisors needed a postdoctorate fellow for six months, so I became a member of staff at WBS – but at the same time, I remained on the other side of that particular threshold as a WBS student: I had two ID badges, two email accounts, two library borrowing accounts...

And then I was forced into identity transitions of a very different nature. Over the following few months, going into 2013, I faced family and health problems which resulted in my crossing thresholds in those areas of my identity as well.

So it might be that I over-think such things, or it might be that I have occupied many liminal spaces and crossed some significant thresholds during the past couple of years, which is why the subject resonates so strongly with me.

And finally, I have crossed a professional threshold: I have moved from clinical to

academic midwife, as I recently started work in a permanent post (I know!) as a postdoctoral fellow in maternity research. As I settle into my new role, I'm drawn to the views of the LMS interviewees: no matter where I go, or what role I take on, I will always carry 'midwife' at the core of my professional identity. Still doing midwifery, just in a different arena.

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Appendix 1: The Cases

	Leading Midwifery Services (case 1)	Midwifery Leadership Development Programme (case 2)	Midwifery Leadership & Clinical Interventions Programme (Case 3)	Developing Self, Developing Others (case 4)
Provider	NHS East Midlands/Arup	NHS East of England/Arup	NHS East of England/Arup	Royal College of Midwives/King's Fund
Cohort	Newly-appointed/ Acting HoM, senior midwives, SoM, senior education/management role	HoM, SoM	Midwives at Band 6/7	Midwives at Band 6/7
Prior Leadership or Management Experience	Yes	Yes	Not necessarily	Not necessarily
Nomination	Self-nomination preferred at design stage	Nomination by Chief Executive and Director of Nursing	Not described	Self-nomination
Pathways	Two pathways: 12-15 midwives on each. Division according to need identified at development centre	Two pathways: 10 HoM on one, 35 SoM on the other	One pathway, cohort divided into two groups, 32 midwives in each	One pathway, 13 midwives
Course content	Path A: leadership programme – 2x2-day residential modules, 3x masterclasses, 3x ALS, stretch assignments. Path B: individual development programme - 1:1 coaching/PDP session, stretch assignments/on the job learning, 3x masterclasses, 3x ALS	HoM: Intensive start – 4 modules, 1 coaching session over three days; Leadership programme – 6x ALS, 3x coaching sessions. SoM: Leadership programme – 6x modules, 4x ALS, 4x coaching sessions.	Development centre day, followed by 1:1 PDP session, 2x modules, 3x ALS, 2x coaching sessions.	Theory-based learning sessions, role play sessions, personal portfolio
Time	6 months	12 months	12 months	6 months

Abbreviations: HoM – heads of Midwifery; SoM – supervisors of midwives; ALS – action learning sets, PDP – personal development planning

Note: all modules take place over one day (apart from residential modules described)

Appendix 2: Interviewees' career journeys

	1975	1980	1985	1990	1995	2000	2005	2010
Deborah		1982 started (nurs)	1985 nurse 1988 midwife		?year headhunted for CC team	2002 matron	2007 senior matron	LMS HoM role
Lesley			1985 started (nurs) 1988 nurse	c1994 midwife	1996 Kings team 1998 G grade CMW	2000 G grade L/S 2002 lecturer	2009 matron	2011 HoM/GM
Natalie	1978 started (nurs)	1981 nurse c1984 midwife	1986 sister 1989 lecturer				2008 LME	
Pauline		1980 started (nurs) 1983 nurse	1986 midwife 1988 CMW				2008 matron (sec) 2009 CMW	2010 risk 2010 matron
Louise					1995 started (mw) 1998 midwife 2000 BP team (sec)	2002 (deputy) WM 2004 WM		2010 matron (sec) 2011 matron (mat)
Heather						2000 started (mw) 2003 midwife	2005 CMW 2006 band 7 CMW 2007 band 7 L/S 2009 matron	
Caroline					1995 started (mw) 1998 midwife	2001 LP 2002 PDM		
Karen	1979 started (nurs)	1983 nurse	c1987 midwife c1989 CMW			2000 LP 2001 CMW mgr sec 2001 CMW mgr		2010 HoM (sec) 2011 matron
Susan	1975 started (nurs) 1978 nurse	1982 midwife 1983 Canada	?year Zone/Region Nursing Officer	1990 UK ?year RTP ?year Sister	?year CMW mgr 1997 HoM	2000 HoM/Child	2005 LSA MO	

Appendix 2 continued: Interviewees' time to current role

	1975	1980	1985	1990	1995	2000	2005	2010	Midwife to current role
Deborah		1982	1988				2007 snr matron		19 years
Lesley			1985	1994				2011 HoM/GM	17 years
Natalie	1978	1984	1989 lecturer				2008 LME		24 years (5 to lecturer)
Pauline		1980	1986					2010 matron	24 years
Louise					1998			2010 matron (sec)	12 years
Heather						2003	2009 matron		6 years
Caroline					1998	2002 PD matron			4 years
Karen	1979		1986			2001 matron		2010 HoM (sec)	14 years (23 to HoM sec role)
Susan	1975	1982					2005 LSA MO		23 years

Colour code:

Began nursing

Qualified as midwife

Current role

Appendix 3: Characteristics of the three online midwifery forums

	The Midwifery Sanctuary	Royal College of Midwives Communities	The Midwifery Forum
Number of users	3174	1249 (but potentially some duplication between areas)	3292
Number of topics	6130	Unknown	4195
Number of posts	252,941	Unknown	Unknown
Sections	Being a midwife; being a student midwife; members only area (time out, birth stories, meeting up, sales & wants); the sanctuary (welcome, feedback and announcements, debate & discussion, book reviews)	Consultations; midwives blog; groups (midwives, student midwives, midwifery support workers, workplace representatives, consultants, professors, research midwives, labour suite coordinators); community members information	Rules & announcements; chat room; want to be a midwife?; student midwives
Activity level	High	Low	Low
Access	Public access to view posts in all areas except 'members only'. Public search facility. Must be registered user in order to comment or post new threads. Administrator activates account.	Must be an RCM member and registered with forum to view posts, join groups and make comments. Membership of some groups requires approval (e.g. consultant midwives)	Public access to view posts in all areas. Public search facility. Must be registered user in order to comment or post new threads
Extras	Members only area for registered users. Registered users can be logged on but 'invisible'	None	None
Privacy	Pseudonyms used. No 'real' photos seen. Can give location if preferred	Pseudonyms can be used. Can give location if preferred. Can link to website	Pseudonyms encouraged. Some members show own photo

Appendix 4: 1st Interview Guide

Introductions:

- Synopsis of study background, including midwifery leadership development in the context of the Next Stage Review, Maternity Matters, current leadership theory, and the talent management agenda;
- Check that the participant has read and understood the participant information sheet (Interviews);
- Give time for any questions the participant may have;
- Outline of today's interview – a loosely structured approach initially, with more focused questions towards the end;
- Assurances of the principles of anonymity, and a reminder that the participant can withdraw from the interview at any time;
- Signing of the consent form by the participant and the chief investigator.

A personal leadership story:

- Participant asked to tell their story, from when they became a midwife, or even further back if they wish to (e.g. what led them into the NHS). Open question, to encourage a full description;
- Guidance as necessary, e.g. 'What year was that?', 'How was that experience?', 'What led you to make that decision?'.

Thoughts on the leadership development programme:

- How and where it fits into the participant's leadership journey;
- What have they learned during the process?
- What issues do they think there will be in practice, in enacting their learning.

Midwifery leadership:

- More generally, what issues does the participant feel there are within midwifery leadership in the profession;
- What impact do they feel the new leadership programmes might have;
- Defining oneself as a 'leader' and/or a 'midwife' – issues arising;
- How the profession views leadership – do they see 'leader' or 'manager'?

Talent management:

- Is the participant familiar with this term?

- If not, give a brief description and context within NHS agenda;
- Does the participant see themselves as talented;
- How might this 'talent' idea fit with new midwifery leadership programmes, and more generally within the midwifery profession.

Conclusions:

- Where does the participant see their journey taking them next;
- Give time for any questions the participant might have, or anything they want to add;
- Remind the participant that they will be contacted in about four months for a second interview;
- Describe transcription of interview, let participant know they are welcome to have a copy of the transcript once completed;
- Thank them for their time.

Appendix 5: Narrative of observational day

Case 2 Celebration Day

The Context

Case 2's celebration day was held at Newmarket Racecourse, and marked the completion of the first Midwifery Leadership Development Programme (MLDP) for Heads of Midwifery and Supervisors of Midwives. The course had been running over 12 months, with delegates attending a variety of types of study days, including modules and masterclasses in leadership theory and practice, and action learning sets, on a monthly basis. Delegates had also had four individual mentoring sessions during the year.

The celebration day also provided an introduction for delegates about to commence the next leadership development course, this time aimed at midwives at Agenda for Change bands 6 and 7.

The East of England had been described in 2008 as the worst performing SHA in the country, with poor leadership thought to be a key element. The SHA appointed Kathy Branson as the lead on education and development in the same year, and the MLDP represents part of the region's commitment to the growth and modernisation of midwifery services, under the banner 'Towards the best, together', and reflecting the NHS Next Stage Review (2008) and Maternity Matters (2007) documents, both of which make numerous references to the importance of appropriate leadership development within the NHS.

On a personal level, the East of England holds some familiarity for me, as I trained at West Herts NHS Trust, although at the time, I had no idea about SHAs and which one the Trust might be part of! But going to these events, I see familiar faces from my student days, and I listen to speakers on the subject of the long-term impact of changes that were made when I was there, such as the merging of two maternity units and the move towards midwifery lead units alongside consultant-led care. I find myself unsure of what I am in these surroundings – a midwife? A student? Still a student midwife? But I feel a kind of pride, as this represents my progress on a journey – the last time I was with these midwifery leaders, I was a student, and keen to leave the Trust as soon as I qualified. And now, here I am, learning about the very structures that fascinated and frustrated me so much ten years ago.

The Day's Events

Kathy Branson gave a history of staff shortages, basic standards, nobody putting their head above the parapet (!), and a sense that there was a lack of leadership ability. She described her preconceptions about staff behaviour when she arrived in 2008, believing she would find de-motivated, defensive staff, and then related how she had been pleasantly surprised when she did not find such attitudes. Instead, she found hard-working and proud staff, struggling to make positive changes in an atmosphere of money-saving and bureaucratic complexities.

Kathy's language was positive and passionate when describing the changes undertaken within the SHA since 2008 – words such as celebration, recognition, and communication –

and she believes the leadership development programme has done much to raise the profile of midwifery in the region, as well as increasing the perceived value of leadership more generally. Kathy detailed a reduction in the caesarean section rate and a rise in the breastfeeding rate over the last two years, and a change in culture towards a 'can do' feeling.

Her final advice to delegates was to roll with the punches rather than ducking them.

I was so excited to hear someone else say 'heads above the parapet'! Kathy's presentation was uplifting and entirely positive – a cynic might ask whether the caesarean section and breastfeeding rates could really have been affected by the leadership development initiatives, for example. Particularly in light of national pressure from various lobbying groups that has been going on at the same time. But I think she was making the point that a culture can be changed, and pinpointed these themes as she knows how passionate midwives are about such issues.

I was chatting over coffee to a couple of the band 6 midwives about to start the programme. One of them commented, "Well, whatever people say about Kathy Branson, at least she's tried to improve things". I didn't get the chance to ask what things people said about her.

There was a ten-minute video presentation, with contributions from Arup staff, who have been designing and managing the programme, and delegates from the course. Again, the feeling was very positive, which reflected the general atmosphere of the day. Midwives described how the course had provided them with the chance to reflect on their leadership practices, and enabled them to see the value of small changes, with change described as a positive and achievable concept. They also mentioned an increased sense of positivity, and a greater ability to delegate responsibilities, which was recognised within their workplace team.

There were echoes of Kathy's presentation here, with a sense that much has changed in the past two years in the East of England. These heads and supervisors of midwives mentioned some cynicism at the outset of the programme, although it was not clear whether this cynicism came from themselves or from elsewhere. I had a real sense of the midwives having undergone a journey, both individually and at a structural level – they described greater confidence in dealing with resistance to change, and working at a strategic level. For the research study, this was interesting – because I wonder how they feel in six months, time. Will they be able to sustain this positive mindset? Will they be supported in their continued development in the workplace? These presentations gave me much guidance in thinking about later interviews – questions about the leadership development journey, on both an individual and wider structural level.

There was an opportunity to view poster presentations. The posters represented work by delegates, based on their individual challenges, undertaken as a continuous thread through the MLDP year. Changes included work to develop the role of midwifery support workers alongside midwives, implementation of healthy living schemes, and planning for midwifery-led units. Common themes included references to resistance to change, and a slow rate of

change. The posters also included delegates' individual reflections on the impact of the programme – as in the video presentation, the themes included increased confidence, self-awareness, development of personal understanding of the ability to lead, and improved understanding and use of a team/sharing/delegating approach to change management.

I was standing looking at the posters, and began chatting with two band 6 midwives about to join the new cohort. They said that, although they were very impressed with the posters, they now realised that the course would mean producing written work, which was not something they had considered. I asked them how they came to be here, and both said they had been approached by their immediate line manager. I told them a little about my research, and asked whether they had ever heard of 'talent management' or a 'talent pipeline'. Neither had, but then they discussed the terms between them, and came to the conclusion that they felt quite flattered, as they now believed their manager must have regarded them as 'talented' in order to nominate them for the course. From the research question point of view, this was an interesting point – maybe this really is talent 'management', my favourite oxymoron!

There followed Powerpoint presentations by other delegates, which, like the posters, described changes implemented (or attempted) during the course of the MLDP. Again, there was some degree of reflection on the impact of the MLDP within all the presentations, with a couple of the delegates becoming quite tearful as they spoke. They variously described the mentoring/coaching approach as a way to increase confidence; the programme as an energy boost on the lifetime leadership journey; action learning sets as a way of learning awareness of other strategies used by fellow leaders; the course as life-changing, and as far more effective than earlier leadership development courses they had attended; and the chance for personal and professional growth.

I wondered how Arup had selected delegates for either poster or Powerpoint presentations. I did notice that the midwives doing Powerpoint were the same ones speaking in the video presentation. The sense of pride in the work undertaken was palpable, and the applause was loud after each one.

Just before lunch, there was a keynote address, given by a female consultant obstetrician, who spoke about the predominance of men leading the NHS, and her personal inspirational figure (Mary Parker Follett), as well as about her own research study.

I was a little surprised at the choice of speaker, given the historical tension between the medical and midwifery professions. I wondered how this speaker had been chosen, and the rationale. I think it may have been based on her study, which described such elements as clinical versus managerial tensions, internal and external loci of control, and the complexities ('the x factor') of leadership.

Over lunch, I chatted with a few delegates just completing the course, and as a group they described the positive impact of the chance to spend time networking with other heads and supervisors of midwives. One, a head of midwifery, described how she had previously felt as though she was leading in isolation – but through attending the course, she had come to understand that her fellow heads of midwifery faced similar problems to her own.

These delegates believed they had built a network through the programme, and that their future leadership would be enhanced by the ability to discuss issues with their peers.

Again, this gave me the sense that I was heading in the right direction for the study – the sustaining of this positive identification of leadership, maintaining individual and group identity as leader, the challenges faced once the course has ended...

Red Zebra and the Midwives' Orchestra

Midwifery, music and leadership: a strange but effective orchestra.

Red Zebra, led by Oliver, transformed the midwives into an orchestra for the afternoon, to demonstrate the importance of team work in leadership. We all had a part to play (I became a triangle player for an hour), and the group worked to form a piece of music made entirely of rhythms (no tuned instruments here, for simplicity's sake!). While Oliver led, the music worked well, and he described how this demonstrated the team approach.

The buzz in the room during the session was palpable. But the silence when Oliver asked for a volunteer conductor was one of acute embarrassment. Eventually, two midwives came forward, and each spent a few minutes leading the orchestra. Oliver commented afterwards, that he felt the orchestra members had worked extra hard to support the new and inexperienced conductor, and again this showed the importance of a team approach to leadership. I was not entirely convinced by his view, as it could be argued that only he, as an experienced leader, was able to direct proceedings effectively, and that under the non-musician conductors the process descended into near chaos.

Oliver has recently become a father – a homebirth, where he greeted his son in a water pool – and he was enormously and effusively positive about the role of the midwife, both on an individual level and in relation to society in general. I wondered how the midwives coped with his exaltation of them: did they think “Oh lovely, but hey, that’s just our job”, or were they in an environment where they could recognise and acknowledge their impact? The ‘talking stick’ circle at the end of the session may give some clues, as several comments were about how midwives should learn to celebrate and express the greatness of their profession.

A few minutes later, sitting back at the tables, I had a conversation with two midwives who are about to start the band 6/7 programme. I was surprised, and a little disappointed if I’m honest, at their reaction to the session. They described Oliver as “a bit patronising”, saying that he “over-egged” the importance of midwives, and they complained that “it was all about him, really”.

For myself, I enjoyed the session enormously, although as usual I was unsure of my role. Identifying myself as a former musician just served to add another layer of complexity, as it seemed to make the other triangle players look to me whenever we were identifying new rhythms. I loved watching how the orchestra worked together, and wondered whether a weekly session of this kind of group work would benefit midwives in the workplace!

I was curious to know how Oliver would have approached the session, had he not recently experienced the world of midwives firsthand...

I feel as though this one day gave me so much food for thought! I think it had something to do with the fact that the day was both an end and a beginning, and for two different groups of midwives (heads/supervisors, and band 6/7s). The sense of optimism and positivity was very strong throughout the day, apart from the single negative moment at the end of the Red Zebra work. I was able to see how the case study approach will work, particularly the ability to look at several programmes that are all quite similar – but that have small differences. I remain unsure of my own place in the research, but for now I think I just need to accept that I am neither true non-participant nor participant – a hybrid of midwife and researcher.

Appendix 6: Heather's Story – an excerpt

Heather describes herself as a late entrant into midwifery. She was married and had two children when she started her training in 2000. Here, she describes her feelings about learning to be a midwife:

“From the first day I started, I knew I was where I needed to be. I'd tried lots of things before that – I'd tried accountancy and all sorts of courses, and I'd given them all up. And then had finally found something that worked for me”.

Heather was a direct entry midwife, undertaking the pre-registration Diploma, and qualifying in 2003.

Direct Entry Midwifery

Heather believes, as a direct entry midwife herself, that “it's the best type of training”. She feels this is due to the three years of dedicated midwifery education she received, as opposed to nurses transferring to midwifery, who complete a post-registration education in just 18 months.

Heather also talks about her belief that direct entry midwives are trained quite differently from nurses:

“As direct entry midwives we tend to be more reflective, more questioning, and I think that's exactly the approach we're taught from day one, and nurses aren't. It's more the directive course that they're given. So – and that's not the same with us”.

She recognises, however, that direct entry midwives may face problems in moving up to Head of Midwifery roles in the future, because the typical Head of Midwifery job also encompasses management of other areas such as gynaecology or paediatrics:

“I think it will be a problem. You know, we don't have any experience of paediatric nursing, or gynaecology nursing. You can't call, you know, a week on the ward when you were a student in your second year, you know (laughing)”.

Equally, though, she points out that this might be less of an issue than it seems, as even Heads of Midwifery who are qualified nurses may not have practised in that role for many years, and are unlikely to be even on the nursing register.

Meta-narratives:

- Debates within midwifery regarding direct entry education
- Midwifery as a separate profession from nursing

Heather describes positive experiences associated with her midwifery education:

“I was really nurtured, I was trained very well. But I also embraced the training and the mentorship that I had, and maybe I got a lot more out of it because I was very enthusiastic”.

Even during her training, she was aware of a need to challenge and be challenged:

“I was given mentors who had been – who were very experienced, been midwives for many years, they came in and did their job very effectively, very good clinicians, excellent communication – but things were done the same way. And I couldn’t ever work out why – I could always see a better way of doing things. And I think that’s one of the things that made me think, well yes, I do want to go up to the next level”.

Heather also recognises another element that drives her to constantly challenge herself:

“I think this fear of failure *drives* me really hard, because I have to be the best that I can be, all the time. And if I’m not the – if I’m not doing the best that I can, I feel absolutely shattered within myself”. After qualifying, Heather remained in the unit where she had trained for a year, and then left to have her third baby. With a husband in the Forces, she has led a life of frequent moving, and when she returned to work after having the baby, she found herself in a different area, and working as a community midwife. Perhaps Heather’s Head of Midwifery recognised her characteristics of needing to be challenged, because a year later – so only two years into working – she recommended that Heather apply for a band 7 post. Helen speaks of questioning her Head of Midwifery’s apparent faith in her, as she had thought of the band 7 role as a distant future career aim: “To me, you know, labour ward coordinators were band 7, team leaders in the community were 7s, and to me that was the pinnacle, you know. You were a manager, and that was somebody that you really respected and who you looked up to”.

Meta-narratives:

- The band 7 role – history and current issues
- Developing leadership – timings
- Social identity of groups

Band 7 Midwives

"I think as a band 7, you have to step up and take on that managerial responsibility, but it shouldn't be all encompassing, I don't think. I think it should be an element – you are managing the shift for that – you know, the midwives on the shift for that day". Heather believes that band 7 is the right place for midwives to begin to develop their strategic knowledge, simply because "managerially, lots more is generally asked of them now". For herself, Heather is able to reflect that as a band 7, "that was the first time, when I really discovered what leadership meant, I think, and how much you could influence as a leader on that particular shift – the culture of the shift, the staff morale, the efficiency of working, smoothness, and the communication, the coordination of activity – and I realised that if you get that right, if you actually start with real basics, as in kindness, respect and just appreciation of each other's roles, the rest would actually fit in".

During the course of undertaking the study, the issue of the band 7 midwives has come up frequently, and I was curious to find out more of the interviewees' views of the group at our second meeting:

BD: Do you think that they are an important group within midwifery?

Heather: Oh goodness, yeah, they're very important. They're a very powerful group.

BD: Do you think they know how powerful they are?

Heather: No, I don't think they do. No, I think actually, they feel they have no power whatsoever to influence anything at all. And that's a constant source of, you know, surprise to me.

Heather has had a turbulent time since becoming a matron, in relation to the band 7 midwives in her unit. She describes how "they've got this idea that that's how management sees them, as this dysfunctional group and everything, and – because I talk up in meetings, I raise – I bring complaints about the unit that we've had, because I think as senior midwives they're at the forefront and they're the ones at the front – because that's where we get a lot of complaints... They feel – they feel it's very negative, they feel very got at, you know".

Heather reports finding the transition from band 6 to band 7 unproblematic, and enjoyed her new role. Six months later, however, her husband was moved once again, and Helen was left trying to find a job in another area.

"I just thought, I'll go back – that's fine, I'll go back to xxx, where I trained, I'll go back to being a band 6 midwife, and I'll be perfectly happy". To her surprise, there were no jobs available at that time, and she spent two months registered unemployed. When a job

became available, it was in another new unit, and would be a band 7 role on labour suite, whereas her previous band 7 post had been within the community setting. Heather applied, despite some anxiety about working as a band 7 in hospital rather than the community, and was successful.

“And I have to say, I absolutely embraced the role. I – it was probably professionally one of the happiest times I’ve ever had. I mean, I’ve always enjoyed every job I’ve had, but that – it was very, very challenging”.

She describes this as a time when she began to develop her core values as a leader, and “found that they saw me through, really – they saw me through a lot. And outside of that, then, you sort of develop everything else, because people trust you, so with that comes confidence in yourself and your own abilities”. She took on some roles outside the basic shift coordination, including, for example, representing the maternity unit for the Clinical Negligence Scheme for Trusts interviews. She remembers feeling somewhat overloaded at times, but embraced the extra responsibility.

After about three years in the role, Heather was approached by her Head of Midwifery and asked to apply for a secondment post as Clinical Services Manager, a matron-equivalent role.

“To me, that would have been a dream job. But I also realised that actually to step up to that, you sort of lose a lot of – probably lose a lot of friends. But I thought, well, what an opportunity, and it was only a secondment, and I thought well, it would give me a sort of a chance to see if I liked the job, so I applied”.

Heather describes a fairly informal interview, in which she was competing against another senior midwife and an external candidate. She was unsuccessful,

“and I was absolutely amazed, because I thought I’d done – I thought I’d put myself forward really well, I thought I’d interviewed well”.

However, on reflection, she realised “that although I knew my role as a leader within being a coordinator, I knew I had my basic core values, and I knew about the shift, actually outside of that labour ward my knowledge of how the NHS worked and how maternity services worked was limited”. At that time, Heather had had no leadership development training in any of the units in which she had worked.

Self-development

On not getting the CSM secondment: “I suppose it knocked my confidence a little bit as well, because I suddenly thought, well, here I am, thinking that everybody thinks I’m this really good midwife, and actually I’ve got these massive holes. And I was wondering actually, have I gone up like this [mimes steep incline] and I’ve missed all these gaps in practice?”

The feedback she received after the CSM interview: “They said that, you know, the person that got it had more strategic knowledge, and a better understanding of budgets and finance and how maternity services were run, what was influencing the practice. Although I felt I had quite a good understanding of that, but I just realised that was something – and also, I’d also realised actually, I would see it – as long as I got that, as long as I learned about that – I would probably be ready for the next stage”.

BD: You recognised that you needed that rounded view?

Heather: Yeah. Yeah. But it was – unless I went out looking for it, it wouldn’t have come to me. Nobody came to me and said, ‘this is what you need, Heather’.

Heather reflects on her own experience of having to take next steps for herself in relation to midwives she now sees rising through the ranks:

“I do appreciate that people don’t think the same way as I do, and they need more support, they need help in identifying where – what they need. And especially, I think – one of the main things I’ve found is that – when I’ve started interviewing midwives. Especially those that are going for more senior roles, and I’ve seen how unprepared they are. They just think they’re going for another band 6 with a bit of an extra, and it’s absolutely not. And even when I was quite junior as a midwife, and I was going for the senior roles, I knew that this was a next step up, and there were expectations, and I would – I’d go and ask, and find out, you know, exactly what the role was going to be, and I felt like, you know, that has been missing. Because – and I don’t – I almost – I try not to think of it as people being lazy, it’s just that people generally don’t know what they need”.

These extracts show evidence of Heather’s reflective nature, but also her belief in self-development rather than drip feeding. As she says, “I don’t think being a matron should ever be something that’s – a role that’s drip fed to you. You have to be prepared to work at it”.

Meta-narratives:

- NHS leadership development – historical and contemporary
- Development according to individual needs (talent management?)

Appendix 7: Data analysis example from online interaction

Question	Themes	Narrative (re-storying)	Counter-narrative from midwifery leaders
1. Midwifery managers	<ul style="list-style-type: none"> • Motives for going into management • Real work is clinical • Leadership and management are different, and often disconnected • Managers as (credible) clinicians and simultaneously effective managers • Different units, different roles • Lack of uniformity re: clinical work 	<p>Midwives become managers because they are fed up with the difficulties of clinical work, or sometimes because they are not effective clinicians.</p> <p><i>"It's fair to say that some managers moved into their current positions because maybe their clinical skills weren't quite up to it, shall we say. That's not to say they aren't good as managers. Although I can think of one who has no observable skills for healthcare, but who has demonstrated an ability to avoid hard work and build up a nice tidy pension"</i> (response to Q1).</p>	<p>The Path to Leadership</p> <p><i>'I wanted to challenge the status quo. I wanted to make a difference on a bigger scale. Some elements of my journey may have been unplanned, but I always knew I needed that challenge.'</i></p>

Appendix 8:

Themes emerging from interviews, with representative quotes

Theme	Variants	Representative quotes
Leaving clinical practice/not working clinically	Would like to work clinically	<p>EM01: “I do have days when I think, you know, it would be really nice to go out and get some hands on. But I don’t actually feel that I’m that far away from the women and the midwives... But yeah, it would be nice, but I think it’s the usual challenge of time and resources” (1:11).</p> <p>EM02: “My instinct [when the unit is busy] is to want to go out and jump in and help them, but that intervention will only last half an hour, maybe an hour, and it will only benefit one or two people that I’ve managed to help out in there” (1:17).</p>
	Does not miss clinical work	<p>EM04: “It depends what are you asking me – what am I missing? Because at the end of the day, 18 years in the community, which I loved to bits – I’ve done it. I’ve, you know, I’ve – you could say, you’ve worn the t-shirt. I’ve moved on now. You know, next – the next chapter of the book is where I’m at. When you’ve read a story, you don’t keep going back to that story, you look for another, you know – what’s coming next?... No, I don’t miss the – the daily clinical hands on antenatal delivery – I’ve done all that” (18).</p>
	Impact	<p>EM03: “I think then I lost some confidence, because if you’re not dealing with the multidisciplinary team, particularly senior people, on a regular basis, you don’t have the same dialogue with them” (1:4). On loss of skills: “If I went on and I was asked to help a woman birth her baby, I could get on with it, but if she started haemorrhaging, where’s the catheter? I know there’s a full bladder – that’s what makes me unsafe” (1:22). “Because you actually lose those skills very, very quickly. Even touch, you will lose it very quickly. However, I can still talk to women. I am still quite happy to support a birthing” (2:28).</p>

Appendix 9: Abbreviations

BMA: British Medical Association

CC: Changing Childbirth

CMW: community midwife

ESRC: Economic & Social Research Council

GM: general manager

HCC: Healthcare Commission

HoM: head of midwifery

LME: lead midwife for education

LMS: Leading Midwifery Services

LSA: local supervisory authority

MO: midwifery officer (head of SoMs)

NHS: National Health Service

NMC: Nursing and Midwifery Council

PDM: practice development matron

RCM: Royal College of Midwives

RCN: Royal College of Nurses

RTP: return to practice

Sec: secondment role

SHA: strategic health authority

SoM: Supervisor of midwives

WM: ward manager